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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SONOMA

261926

TERESA BROOKE,

Plaintiff,

vs.

AURORA BEHAVIORAL HEALTHCARE – SANTA ROSA, LLC and SIGNATURE HEALTHCARE SERVICES, LLC, and DOES 1 through 100, inclusive,

Defendants.

Case No.: SCV 261926

Unlimited Civil Case

COMPLAINT FOR:
1. Wrongful Termination in Violation of Public Policy
2. Retaliation in Violation of Cal. Labor Code § 6310
3. Retaliation in Violation of Cal. Health & Safety Code § 1278.5
4. Retaliation in Violation of Cal. Labor Code § 1102.5
5. Misrepresentation in Violation of Cal. Labor Code § 970
6. Intentional Misrepresentation
7. Negligent Misrepresentation
8. Private Attorneys General Act Enforcement
9. Injunctive Relief Pursuant to California Business & Professions Code § 17200

JURY TRIAL DEMANDED

Plaintiff TERESA BROOKE ("Plaintiff"), by her attorneys, brings this action on behalf of herself against Defendant AURORA BEHAVIORAL HEALTHCARE – SANTA ROSA, LLC ("AURORA"), Defendant SIGNATURE HEALTHCARE SERVICES, LLC

("SIGNATURE"), and DOES 1 through 100 (collectively, the "Company"). Plaintiff hereby alleges as follows:

I. INTRODUCTION

1. Plaintiff TERESA BROOKE has spent her career as a nurse and hospital manager caring for some of the country's most at-risk patients—those in need of acute psychiatric care.

2. In early 2016, Plaintiff packed up her life in Virginia, left a well-paying job with high-quality benefits, and journeyed across the United States to take up a position as Chief Nursing Officer at the Aurora Santa Rosa Hospital ("the Hospital")—a psychiatric hospital in Santa Rosa, California owned by the for-profit psychiatric hospital chain SIGNATURE and operated under its AURORA brand.

3. Plaintiff arrived at the Hospital to find dangerous conditions unlike anything she had encountered in her 30 years of nursing. Running on a shoestring budget from corporate leadership at SIGNATURE, the Hospital was plagued by a high incidence of injuries resulting from understaffing of the skilled nurses and other caregivers needed to care for high-needs patients. While the overriding goal of clinicians like Plaintiff was "safety first," the Company's overriding concern was increasing patient census (or, headcount) and minimizing costs. For the Company, profits came first and patients dead last.

4. The Company's greed left patients without adequate care and supervision and put lives at risk. Outdated practices long abandoned by the psychiatric community flourished at the Hospital; without sufficient Medicare/Medicaid-required therapeutic programming that would impart coping tools and prepare patients for discharge, patients were "warehoused," left with little to do other than pace up and down the halls of the unit or sit in front of a television. There were not enough staffers to provide anything but the most basic supervision, and sometimes not even that. The Hospital's underpaid and overworked staff of nurses and mental health workers faced repeated violent outbreaks among patients. Lacking sufficient numbers to control patients, staff and other patients were subjected to routine punching, kicking, choking, and, on one occasion, even a full-blown patient riot. And, the dearth of staff led to high incidence of patient

self-harm and multiple occurrences of sexual violence involving patients, some of them minors.

5. In response to the Hospital's dangerous conditions, Plaintiff made patient and staff safety her top priority. She did all she could to resist corporate pressure to increase patient headcount in a facility that could not handle its existing patients. She instituted patient admissions caps and insisted that AURORA not open an additional patient unit, at SIGNATURE's behest, without the staff needed to operate it safely. She advocated for the Company to raise its paltry wages to enable the Hospital to recruit and retain clinical staff, and she temporarily plugged staffing gaps with travel nurses, to the displeasure of SIGNATURE. In short, Plaintiff put safety ahead of short-term revenue and profit.

6. After months of Plaintiff's safety-first advocacy, corporate leaders had had enough. In late October 2016, the Company abruptly fired AURORA's Chief Executive Officer, who had supported Plaintiff's recommendations, including postponing the opening of the new unit and capping admissions. As interim CEO, SIGNATURE appointed AURORA's Chief Financial Officer—an executive lacking relevant clinical experience but committed to SIGNATURE's financial goals. Seeing the futility of her internal resistance and fearing that the new unit would open before staffing levels could support it, Plaintiff complained to the California Department of Public Health ("CDPH"), blowing the whistle to the government about AURORA's severe, dangerous, and illegal understaffing.

7. Less than a month later, on the day after Thanksgiving 2016, SIGNATURE and AURORA retaliated, firing Plaintiff without warning because she would not silently abide the Company's push for profits over the rights of patients and staff. Shortly after, CDPH substantiated and validated Plaintiff's complaint about understaffing and unsafe conditions at the Hospital.

8. With this lawsuit, Plaintiff seeks to end the dangerous conditions at AURORA and to recover damages for the harm she has suffered.

II. JURISDICTION AND VENUE

9. This case is properly before this Court because it involves issues of state law, and

all Defendants conduct substantial and continuous commercial activities in Sonoma County.

10. The amount in controversy in this matter exceeds the sum of $25,000.00.

III. THE PARTIES

11. Plaintiff TERESA BROOKE was a California resident throughout her employment by Defendants. Plaintiff worked for Defendants in California as AURORA's Chief Nursing Officer from May 2, 2016 to November 25, 2016.

12. Defendant AURORA BEHAVIORAL HEALTHCARE – SANTA ROSA, LLC is a California limited liability company with a principal place of business and headquarters in Santa Rosa, California. At all relevant times, AURORA was an employer or joint employer of Plaintiff and is an "employer" as that term is defined in California law.

13. Defendant SIGNATURE HEALTHCARE SERVICES, LLC is a Michigan-based limited liability company with its principal place of business in Corona, California. At all relevant times, SIGNATURE was an employer or joint employer of Plaintiff and is an "employer" as that term is defined in California law. At all relevant times, SIGNATURE was the owner, operator, and parent company of AURORA.

14. Upon information and belief, Defendant AURORA and Defendant SIGNATURE, and each of them, are subject to such a degree of common ownership, control, and management that, in doing the things hereinafter alleged, each corporation was the agent of each other corporation and is liable to Plaintiff under the law for the damages sustained by Plaintiff.

15. In doing the acts herein alleged, each and every Defendant was the agent, representative, employee, servant, or affiliated entity of every other Defendant, and each Defendant is liable and responsible to Plaintiff for the acts of every other Defendant.

16. Defendants, through their officers, managing agents, employees, and/or supervisors authorized, condoned, and/or ratified the unlawful conduct described herein.

17. Upon information and belief, each Defendant was Plaintiff's employer under California law; all of the Defendants did acts consistent with the existence of an employer-employee relationship with Plaintiff.

18. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants Does 1 through 100, are unknown to Plaintiff, who therefore sues these Defendants by such fictitious names. Plaintiff will amend this Complaint by inserting the true names and capacities of each such Defendants, with appropriate charging allegations, when they are ascertained. Upon information and belief, each of the Defendants designated herein as a "DOE" is responsible in some manner for the injuries suffered by Plaintiff and for damages proximately caused by the conduct of each such Defendants as herein alleged.

19. Defendants AURORA, SIGNATURE, and Does 1 through 100 have such a unity of interest and ownership that separate personalities do not in reality exist and the corporate structure is just a shield for the alter ego of each other. Inequity will result if the acts in question are treated as those of one of these Defendants over the other. Defendants AURORA and SIGNATURE and DOES I through 100 should be held collectively liable for the acts complained of herein.

IV. FACTUAL ALLEGATIONS COMMON TO MULTIPLE CAUSES OF ACTION

a. The Hospital Operated Under a Myriad of Cal-OSHA Violations

i. Understaffing Creating a Dangerous Environment for Hospital Staff and Patients

20. In or about Plaintiff's first week of employment in early May 2016, AURORA's then-CFO, Susan Rose, provided her with a spreadsheet showing the Hospital's 2016 staffing budget, breaking down the budgeted headcount of Registered Nurses ("RN"), Licensed Vocational Nurses ("LVN"), Licensed Psychiatric Technicians ("LPT"), and Mental Health Workers ("MHW") per shift, per hospital unit.

21. Also in or about her first week of employment, Plaintiff began holding one-to-one meetings with the Hospital's various director-level personnel. During these meetings, directors began sharing their concerns with Plaintiff that the Hospital was understaffed. California law requires that hospitals staff their units to meet "patient acuity," i.e., the intensity of nursing care and attention that a patient requires. Upon information and belief, Plaintiff learned from her staff

that, because of AURORA's understaffing, the Hospital was unable to comply with the acuity-based staffing requirements set by law.

22. Upon information and belief, at the start of Plaintiff's employment, the Hospital's nurse-to-patient ratio was often less than a third of the California minimum standard (at least 1:6 nurses-to-patients), falling as low as one nurse to 19 patients on occasions. Upon information and belief, this ratio fell even lower on some nights and weekends or when nurses called in sick.

23. Upon information and belief, the Hospital's understaffing was rooted in its budget. Plaintiff learned that the compensation and benefits offered to the Hospital's nurses and other staff were well below market. As a result, the Hospital had difficulty hiring experienced, permanent nurses. With low salaries and long shifts in a stressful and chaotic working environment, staff quit often, and the Hospital struggled to fill the gaps with new recruits.

24. Additionally, the sparse staffing budget limited the Hospital's ability to adjust staffing on a shift-by-shift basis to meet the fluctuating needs of patient acuity. For example, if a unit added patients requiring one-on-one supervision or if staff had to call in sick, Ms. Rose would tell Plaintiff that staffing the necessary nurses or other caregiver staff for that particular shift was not in the budget.

25. The outcome of these budgetary restrictions was chronic understaffing, high turnover, and a dangerous proportion of nurses and staff with little experience. These unsafe conditions and practices led to staff suffering preventable injuries regularly and created a work environment rife with risks to staff and patients.

26. With insufficient staffing to monitor the units and insufficient programming to occupy its patients, the Hospital experienced injuries to staff and patients at a frequency and severity that alarmed Plaintiff. Patients engaged in self-harm at high rates and caused uncontrolled physical destruction to the Hospital itself—destroying chairs, punching walls, and throwing things. When staff tried to stop this behavior, and in the course of routine interactions with patients, staff faced all manner of assault—punching, kicking, spitting, scratching, and biting. One mental health worker was assaulted on the unit so many times that she had to be

transferred out of patient care and into an HR position.

ii. Insufficient and Overcrowded Nurses' Stations

27. Throughout Plaintiff's employment at the Company and upon information and belief continuing today, the design of the Hospital's nurses' stations has resulted in unsafe working conditions for nursing and caregiver staff.

28. At the time of Plaintiff's employment, the Hospital contained four operational patient units. These units were supervised by a total of two nurses' stations, with two pairs of units each supervised by a single nurses' station. The nurses' stations were too small for the approximately 20 caregivers (including but not limited to nurses, MHWs, LVNs, LPTs, and physicians) who might be expected to utilize them at any given time.

29. From these cramped stations, nurses and other caregiver staff were expected to complete paperwork and charting responsibilities, administer medications, and coordinate the supervision of nearly 40 patients. However, these small units were so overcrowded that staffers were unable to safely execute their job responsibilities. The design of these nurses' stations resulted in inadequate supervision of patients and increased risk of injury to both patients and staff.

30. Upon information and belief, these conditions are an ongoing and current safety risk to all AURORA nurses and caregiver staff.

iii. Unsafe Placement of Patient Seclusion/Restraint Rooms Inside Nurses' Stations

31. Throughout Plaintiff's employment at the Company and upon information and belief continuing today, the placement of patient restraint rooms inside nurses' stations in the Hospital has resulted in unsafe working conditions for AURORA's nursing and caregiver staff.

32. The purpose of restraint rooms in mental health facilities is to provide a safe place for patients exhibiting violent behavior where they will not cause harm to other patients or Hospital staff. Upon information and belief, it is highly unorthodox to locate such rooms within the nurses' stations of a unit. In Plaintiff's decades of experience in her profession, she never has

seen such an arrangement.

33. The design and placement of restraint rooms at the Hospital creates an unsafe environment. Except when brought to the restraint room, patients are never permitted to enter the nurses' stations. When patients exhibiting violent and dangerous behavior are brought into the restraint rooms, however, they must be walked into and through the cramped nurses' stations, coming within inches of computers, pens, scissors, and other supplies that could cause serious harm to staff and other patients.

34. Upon information and belief, the placement of restraint rooms within the nurses' stations constitutes an ongoing safety risk to all AURORA nurses and caregiver staff. All current and former nurses and caregiver staff working in the vicinity of the nurse stations have been subjected to this unsafe work environment.

iv. Unsafe Administration of Patient Medication

35. Throughout Plaintiff's employment at the Company and upon information and belief continuing today, the distribution of medication in two of the Hospital's patient units through their adjacent nurses' station's window has resulted in unsafe working conditions for nursing and caregiver staff.

36. At two of the Hospital's patient units, the distribution of medication takes place through a window in the attached nurses' station. Upon information and belief, based on Plaintiff's experience, in most hospitals and in the other two AURORA patient units that were operational, an entirely separate room is typically reserved for the administration of medication to patients. Such an arrangement enables personnel to administer medication in a way that protects physical safety of staff and patients and allows the substances to be distributed in a confidential, careful, and non-hurried manner to patients.

37. The design and practice of medication administration at two of the Hospital's units, however, does not permit privacy, safety, or careful distribution of medication in those units. There is no separate room for medication administration, just the overcrowded and busy nurses' stations. Consequently, the risks of inaccurate distribution and improper disclosures of

confidential medical information skyrocket. As nurses attempt to dispense medicine through a window in the station, patients often try to reach through the window and grab handfuls of other patients' medications. Administering medication from the chaotic environment of the nurses' station increases the risks that patients or staff might be hurt in the process.

38. Upon information and belief, the Hospital's system for administration of medication causes ongoing and current safety risks to all AURORA nurses, caregiver staff, and patients.

v. Insufficient Hand Washing Stations

39. Throughout Plaintiff's employment at the Company and, upon information and belief continuing today, AURORA's failure to provide sufficient hand washing stations and sinks for staff use has resulted in unsafe working conditions for AURORA nursing and caregiver staff.

40. Upon information and belief, the Hospital maintains one sink at the back of each of the Hospital's two nurses' stations, one sink in one of the Hospital's restraint rooms, one sink in each of the four units' refreshment areas, one sink in each of the Hospital's two medication rooms, and one sink in each patient room. However, out of these handwashing areas, only the two nurses' stations sinks and the sinks in the refreshment areas are readily available and accessible for use by staff. The restraint room sink and medication room sinks were generally inaccessible, as those rooms were kept locked unless a patient was in restraint or medication was being retrieved. Similarly, the sinks in patient rooms were restricted for patient use, and staff could not realistically or safely access them. This dearth of sinks created an unnecessary health risk to patients and staff.

41. Upon information and belief, all current and former nursing and caregiver staff are aggrieved by the dearth of facilities and supplies for handwashing.

vi. Failure to Implement an Injury and Illness Prevention Program

42. Throughout Plaintiff's employment at the Company and upon information and belief continuing today, AURORA's failure to implement and maintain an Injury and Illness

Prevention Program ("IIPP"), as required by California law, has resulted in unsafe working conditions for AURORA's nursing and caregiver staff.

43. Upon Plaintiff's hiring, AURORA had no IIPP, written or otherwise. During Plaintiff's employment and, upon information and belief, continuing to the present, AURORA did not maintain a written IIPP, did not train all employees about the program, and did not correct unsafe and unhealthy conditions in a timely manner. Upon information and belief, Julius Schillinger, AURORA's HR Director from about March 2016 to about September 2016, began writing an IIPP. However, during Plaintiff's employment, no IIPP was discussed with Plaintiff and she was not aware of any announcements or trainings about the adoption of an IIPP. During Plaintiff's employment period, no IIPP was implemented. Upon information and belief, AURORA never complied with the IIPP requirements of California law.

b. <u>The Company Failed to Provide Employees with Suitable Seating</u>

44. Throughout Plaintiff's employment and, upon information and belief, continuing to the present, AURORA has failed to provide seating suitable to the needs and numbers of its nursing and caregiver staff. The job duties of the staff include significant amounts of time filling out paperwork, updating charts, and maintaining files and documents. Upon information and belief, aside from C-level employees and managers, who had their own private offices, the only workspaces available to nurses and caregiver staff were two tiny nurses' stations, connected to the Hospital's patient units.

45. Upon information and belief, these nurses' stations and the counter space within them were too small to allow nurses and caregiver staff to complete their paperwork. Upon information and belief, while upwards of approximately 20 staffers might need to occupy each nurses' station on a typical day and spend hours per day on paperwork, there were only a handful chairs in each station. Nurses and caregiver staff were routinely forced to complete paperwork elsewhere—sitting on the Hospital's floors, in vacant seclusion rooms designated for patients' use, and even sitting in the bathroom. Without enough seats or counter space, the staff were forced to do their paperwork in inappropriate, unsafe, and unsanitary locations.

c. The Company Maintained Illegal Confidentiality Policies and Practices

46. As a condition of employment, the Company required Plaintiff to enter into a confidentiality agreement. The agreement's broadly written provisions encompassed the confidentiality of information about employees and their working conditions, including *inter alia* "human resources," "internal reporting," "communications," "employees" and "management information." As stated in the agreement, violation of the agreement may result in discipline, including termination. Upon information and belief, the Company's confidentiality policies and practices were uniform for all employees.

47. Upon information and belief, the Company's confidentiality policy was enforced as a matter of corporate policy and practice, and daily corporate culture. As described below, Plaintiff reported AURORA's poor working conditions for nurses to the California Department of Public Health ("CDPH"). Upon information and belief, the Company enforced its confidentiality policy against Plaintiff when it fired her in retaliation for her complaint.

48. Upon information and belief, all current and former California employees of AURORA and SIGNATURE are aggrieved by an illegal confidentiality policy, and such violations are continuing and ongoing.

d. SIGNATURE Demanded Increased Patient Headcount and Reduced Expenses, Resisting Plaintiff's Efforts to Ensure Safe Staffing Levels

49. After learning the extent of the Hospital's understaffing problems, in or about the first two weeks of her employment, Plaintiff notified AURORA's then-CEO Kay Seim of her concerns. Fearing for the safety of the Hospital's patients and staff, Plaintiff repeatedly notified the Company's leadership of AURORA's understaffing throughout the succeeding months, including *inter alia* during daily "flash meetings" with C-level executives and directors and in weekly one-on-one meetings with Ms. Seim.

50. Plaintiff regularly advised Ms. Seim to institute temporary holds on admissions, halting admissions of patients into certain units for short periods of time (such as 8 hours blocks) if there were not enough nurses available to safely or legally supervise more patients. On such

occasions, Ms. Rose frequently demurred, commenting that corporate would not like such admissions holds.

51. Ms. Seim acknowledged Plaintiff's concerns about understaffing and supported her efforts to improve staffing. She allowed Plaintiff to hire travel nurses (experienced but expensive nurses hired on short-term contracts) and permitted Plaintiff to cap patient admissions Hospital-wide, as necessary.

52. At the same time, Plaintiff collaborated closely with the Hospital's Human Resources department, then led by HR Director Julius Schillinger. In or about July 2016, after Mr. Schillinger informed her that he could not find an AURORA pay policy, Plaintiff created a tool for setting and adjusting fair pay for nurses (in accordance with experience, seniority, and other variables). Plaintiff worked closely with HR on various other measures to shore up recruitment and retention, work toward employment law compliance, and otherwise improve the workplace for the staff.

53. However, the Company opposed Plaintiff's caps on patient admissions and failed to increase AURORA's staffing budget. Upon information and belief, AURORA CEO Kay Seim was under constant pressure to increase patient census and control expenses from her boss, Blair Stam, Executive Vice President of SIGNATURE. Mr. Stam runs SIGNATURE from its main California office in Corona. AURORA CFO Susan Rose and SIGNATURE's Vice President of Clinical Operations, Michael Sherbun, also focused on increasing patient census while limiting the Hospital's spending, the vast majority of which consists of labor expense.

54. For example, on September 8, 2016, Mr. Stam ordered Ms. Seim to provide a plan of correction for increasing census and controlling expenses. Ms. Seim's corrective measures included stopping the practice of consulting with doctors and psychiatrists about the medical conditions of the patients, having Seim take over the Administrator-on-Call ("AOC") role until census increases,[1] and putting the CNO on call to deal with the problem of RNs being too busy

[1] The AOC is a hospital's individual designated to be on-call 24/7 for after-hours decisions on patient admissions and other pressing questions. Previously at the Hospital, the AOC role rotated on a roughly weekly basis between a number of management-level employees.

to conduct medical screening examinations.

55. Upon information and belief, Ms. Seim was under pressure to increase admissions overall, including after-hours. The Hospital regularly faced the prospect of additional patients being presented for admission after-hours when the Hospital lacked sufficient staff to care for them or lacked the clinical resources to provide for certain medical needs. In such cases, on-duty nurses would often alert the AOC that the Hospital was not able to accept the new patients. Therefore, Seim's taking over the AOC role was designed to reverse the denial of admissions after-hours, thereby increasing patient headcount and profits.

56. From the time that Ms. Seim took over as AOC to late October 2016, Plaintiff interceded with Ms. Seim after-hours to recommend denial of admissions when necessary for health and safety reasons. From the time that Ms. Seim took over as AOC to late October 2016, whenever Plaintiff called Ms. Seim to request that a patient's admission be denied or postponed for such concerns, Ms. Seim followed Plaintiff's recommendation.

57. When Plaintiff sought to hire additional staff or to assign more staff to particular shifts in order to meet patient acuity needs, AURORA CFO Rose told Plaintiff on multiple occasions that AURORA's budget was already set and could not be increased. Ms. Rose publicly expressed her displeasure with additional expenditures when Plaintiff lobbied for temporary stopgap measures, such as bringing on travel nurses. Ms. Rose largely disregarded Plaintiff's concerns for safety and stressed that the Hospital should try to get by with as few staff as possible, saying it was better to be understaffed than overstaffed.

58. As a result of the Company's refusal to increase its budget to meet staffing needs, the Hospital saw high turnover, was unable to recruit and retain sufficient qualified staff, and was beset by avoidable staff and patient injuries and incidents. Staff and patients alike were hurt by long, unpredictable periods of low staffing and 14-to-16-hour work days. The injuries to staff resulting from overwork and understaffing exacerbated staffing deficiencies and, because patients were chronically under-supervised, led to commonplace injuries and violent incidents among patients. The Hospital's units were so understaffed that sometimes patients had to help

nurses and staff control other aggressive patients. At one point, in or about the fall of 2016, a unit of adolescent patients staged a riot—storming the nurses' station, attacking other patients, and attempting to break out of the Hospital. The Hospital was too understaffed to control the situation and had to call the police to quell the riot.

e. SIGNATURE Pressed to Open a Fifth Patient Unit Despite Understaffing

59. At the start of Plaintiff's employment, the Hospital consisted of four operational units in which patients could be admitted. Also on the Hospital's campus was a fifth patient unit that AURORA lacked sufficient staff to open to admissions.

60. SIGNATURE made it clear to AURORA's management that it wanted to begin admitting patients into the fifth unit in 2016. In or about the summer of 2016, the Company's corporate leadership began to increase pressure on AURORA, and particularly CEO Ms. Seim, to open this unit, which would raise revenues by filling beds. Upon information and belief, Corporate leaders at SIGNATURE, including Mr. Stam and Mr. Sherbun, were insistent that AURORA open the fifth unit as soon as possible. AURORA set several dates by which to open the fifth unit, but each time, AURORA had to postpone the opening due to Plaintiff's insistence that there be adequate staffing before increasing admissions so radically.

61. For example, one of the scheduled opening dates was in or about August 2016. As this scheduled opening of the fifth patient unit approached, Plaintiff informed Ms. Seim that, as the Hospital's top clinical authority, she believed opening the fifth unit for admissions would be dangerous and unsafe because AURORA often did not have sufficient staff to manage four units, let alone to safely supervise an influx of new patients into the fifth unit. Additionally, on or about July 23, 2016, one of AURORA's psychiatrists called Plaintiff to express concerns about patient safety if the Hospital opened its fifth unit under the current staffing shortage. Plaintiff notified Ms. Seim of these concerns at the next "flash" meeting with C-level executives and directors. Upon information and belief, as a result of Plaintiff's advocacy, Ms. Seim postponed the fifth unit's opening and informed AURORA's management of her decision.

62. Later in the summer or fall of 2016, the Company was again scheduled to open

the fifth patient unit, but AURORA remained understaffed and unprepared to supervise an additional unit's worth of patients. This consensus was shared among lower-level staff, but SIGNATURE wanted to press on regardless. On or about September 28, 2016, nurse Shawnna Fox sent an email to Plaintiff, CEO Ms. Seim, and another employee complaining about staffing shortages, overwork, and the resulting detriment to the quality of care for patients. Ms. Fox often complained, verbally and in writing, that AURORA was understaffed and that it generally put financial concerns above patient safety and care. When Ms. Rose learned of this complaint, she told Plaintiff that Ms. Fox should be fired for it. Plaintiff dismissed this suggestion. Instead, Plaintiff, as the head of the nursing staff, agreed with Ms. Fox's concerns.

63. Shortly after Ms. Fox made this complaint, Plaintiff again informed her boss, Ms. Seim, that it would be impossible to safely open the fifth patient unit until additional trained staff were available. Ms. Seim again postponed the opening.

f. SIGNATURE Abruptly Fired CEO Kay Seim

64. SIGNATURE maintained pressure to open AURORA's fifth unit for several months. Plaintiff continued to advise the AURORA CEO Ms. Seim not to do so until there were enough staff to safely manage the new unit. In the meantime, Ms. Seim continued to permit Plaintiff to cap admissions in order to mitigate ongoing problems with inadequate staffing.

65. Plaintiff continued to express concern about understaffing regularly, including for example, on or about October 17, 2016 and October 18, 2016.

66. On October 19, 2016, Plaintiff spoke with Mr. Sherbun, SIGNATURE's Vice President of Clinical Operations overseeing AURORA. Plaintiff informed him that there were safety issues at the Hospital, primarily stemming from understaffing, and told him that it was not appropriate to open the fifth unit until the existing problems were addressed. Mr. Sherbun generally avoided discussing staffing concerns with Plaintiff, and when he did respond to Plaintiff's concerns in passing, he expressed general disdain for capping patient admissions.

67. Also on October 19, 2016, Plaintiff met with CEO Ms. Seim, to discuss these concerns and informed her that she was not receiving necessary and expected support from

SIGNATURE executives that she needed to fulfill her duties as CNO.

68. On or about October 26, 2016, Plaintiff twice asked Mr. Sherbun if she could discuss her staffing concerns with him. Each time, he replied, "Later."

69. On October 27, 2016, after Plaintiff had spent months advising her direct and indirect bosses not to open the fifth unit, on behalf of SIGNATURE, Mr. Sherbun visited the Hospital and abruptly fired Ms. Seim in person. SIGNATURE appointed CFO Susan Rose as interim CEO and later made her the permanent CEO.

70. Upon information and belief, Ms. Seim was fired because of her failure to open the fifth unit to new patients, her failure to increase patient census, and her failure to reduce spending, within the timeframe(s) that SIGNATURE wanted.

71. The same day, October 27, 2016, Mr. Sherbun spoke to Plaintiff, telling her that the Hospital had to improve its patient census. Plaintiff asked him how they could do that without more RNs, to which Mr. Sherbun said nothing but just gave her a dirty look. Plaintiff made plans to continue the staffing discussion with Mr. Sherbun later that day, but Mr. Sherbun left the Hospital before they could meet.

72. On the afternoon of October 27, 2016, Plaintiff spoke with Ms. Rose, now interim CEO, and expressed her dismay that Ms. Seim had been fired. While in Ms. Rose's office, Plaintiff again expressed her concerns about understaffing and safety. She said to Ms. Rose that she now had no one to support her on staffing issues and in postponing the opening of the fifth unit. Ms. Rose replied, "you don't have to be scared. We just have to open up another unit." She was sympathetic in her manner but clear about what the corporate higher-ups expected.

g. <u>Plaintiff Filed a Complaint with the California Department of Public Health As Defendants Proceeded to Increase Patient Admissions</u>

73. Fearing a worsening of health and safety conditions, on Friday, October 28, 2016, Plaintiff filed an online complaint to the CDPH, writing:

> Nurse staffing unsafe. State laws for minimum RN ratios not being honored. Many staff have been injured, increased negative patient events, minimal required patient programming not being performed, and staff fatigue occurring related to overtime. CNO notified corporate executives (CEO and VP) of

staff shortages for several months.

> Corporate executives are continuing to push new patients to increase our census when CNO has declared inability to provide RN and unlicensed coverage for short and long term outlooks. Wages not competitive, staff complaining of unsafe working conditions, nursing staff are leaving.

74. In her CDPH complaint, Plaintiff declined the option to remain anonymous and identified herself as the Hospital's CNO.

75. On October 31, 2016, the following Monday, Plaintiff held a staffing meeting with some nursing staff and managers. Staff morale was low following Ms. Seim's sudden termination. At this meeting, Plaintiff informed attendees, including HR Director Mr. Jennings (who had returned to AURORA following Mr. Schillinger's departure in September 2016), that she filed a CDPH complaint in order to get help from the State in protecting patients and staff.

76. Also on Monday, October 31, 2016, AURORA CEO Susan Rose asked Plaintiff to get onboard with increasing patient census and lifting the admissions cap, informing Plaintiff that there had been a cap for weeks and that it needed to be removed. Plaintiff replied that there were insufficient staff to lift the cap and firmly expressed her opposition to lifting the cap.

77. Following this, Ms. Rose overrode Plaintiff's professional judgment and herself lifted the patient admission cap. On multiple occasions, when Plaintiff advocated to stop an admission due to understaffing, Ms. Rose overruled her and told Plaintiff that "corporate" insisted that AURORA admit all potential patients without regard for staffing.

78. Upon information and belief, Ms. Rose also tried to suspend the use of travel nurses but had no choice but to honor their existing contracts.

79. Additionally, Ms. Rose reversed Ms. Seim's policy of following Plaintiff's recommendations to limit after-hours admissions when there were insufficient staff or other health and safety concerns. After AURORA and SIGNATURE fired Ms. Seim, interim CEO Susan Rose took over as AOC and did not seek Plaintiff's clinical recommendations regarding the safety of after-hours admissions. Plaintiff herself took the initiative to call Ms. Rose after hours to offer recommendations to decline admissions for health and safety reasons. Indeed, during the one-month period of Plaintiff's employment while Ms. Rose was interim CEO, Ms.

Rose ordered admissions of patients in every instance where Plaintiff advocated capping or declining admissions for health and safety reasons. Ms. Rose declined to admit only one patient, and that was because the patient had a history of non-payment.

80. Upon information belief, under directive from corporate leaders at SIGNATURE, Ms. Rose worked to maximize the number of patients admitted to the Hospital regardless of health and safety risks. Based on Plaintiff's knowledge, observations, and professional judgment, within days after Ms. Rose's appointment to interim CEO, Ms. Rose's decision to increase patient census without requisite staff to supervise them resulted in an incident of patient sexual violence in which one patient, who should have been under one-on-one supervision after exhibiting violent sexual tendencies but who could not receive that supervision with the numbers of available staff, sneaked into the room of and sexually assaulted another patient.

81. On both November 2, 2016 and November 3, 2016, Mr. Sherbun again avoided talking to Plaintiff as she tried to discuss with him the pressing need to limit patient admissions and increase staffing.

82. On November 3, 2016, Jim Shannon, a representative of the Licensing & Certification Program of the CDPH, visited AURORA in response to the patient sexual incident that had occurred days earlier. Mr. Shannon met with Plaintiff and others that day, and upon meeting Plaintiff, he inquired if she was the CNO who had recently made a complaint to CDPH regarding understaffing. Mr. Shannon showed Plaintiff a letter depicting the body of her complaint, with her name on it. Plaintiff answered affirmatively. Mr. Shannon replied that CDPH would also be investigating her complaint.

83. Upon information and belief, CDPH was investigating the Hospital on its own behalf and on behalf of the Centers for Medicare and Medicaid Services, a branch of the U.S. Department of Health and Human Services.

84. Mr. Shannon of CDPH asked that Plaintiff provide him with material to conduct his investigation including, *inter alia*, an accounting of the Hospital's patient census, a schedule of staff for the next two days, and a list of clinical staff along with their dates of hire.

85. From about November 3 to November 9, 2016, Plaintiff was the primary point of contact for Mr. Shannon and spent considerable time speaking with him and assisting him in his investigation. Plaintiff provided candid and full information in response to the CDPH investigation. Every day after Mr. Shannon left the Hospital, Plaintiff would brief AURORA CFO Ms. Rose and/or SIGNATURE VP of Clinical Operations Mr. Sherbun regarding the CDPH investigation.

86. On November 10, 2016, Plaintiff left for a pre-scheduled vacation out of the country. Plaintiff was scheduled to return to work on or about November 25, 2016, the day after Thanksgiving.

87. Upon information and belief, while Plaintiff was on vacation, on or about November 17, 2016, Mr. Shannon made a surprise visit to AURORA to further investigate her complaint.

h. AURORA and SIGNATURE Fired Plaintiff Right After the CDPH Investigation

88. On November 25, 2016, the day after Thanksgiving, Mr. Jennings asked Plaintiff to meet him in AURORA's conference room around mid-morning. In the conference room, Mr. Jennings informed her that she was terminated, effective immediately. Plaintiff was then given two pieces of paper, an Employee Corrective Action Report and a Termination of Employment, both bearing the authorizing signature of Susan Rose as CEO of AURORA. Both said only, "Performance does not meet expectations." Plaintiff asked Mr. Jennings why her performance did not meet expectations, but he provided no explanation. Mr. Jennings told her to pack her belongings right away, and he escorted her to her car as soon as she was packed up.

89. Plaintiff received only one performance review during her employment, on or about August 23, 2016. In this review, Plaintiff was evaluated on 10 performance standards and she was rated as *exceeding* or *meeting* all expectations.

90. At no time during her employment, except at her termination meeting, was Plaintiff informed by anyone at AURORA or SIGNATURE that her job performance was not

meeting expectations.

91. Upon information and belief, before firing Plaintiff, AURORA and SIGNATURE knew that Plaintiff complained to CDPH about health and safety issues, including understaffing, at the Hospital.

92. Upon information and belief, before firing Plaintiff, AURORA and SIGNATURE knew that Plaintiff provided candid information to CDPH about health and safety issues, including understaffing, in the course of CDPH's investigations on behalf of CDPH and the Centers for Medicare and Medicaid Services.

93. Upon information and belief, before firing Plaintiff, AURORA and SIGNATURE believed that Plaintiff would in the future provide candid information to government authorities and regulators about health and safety issues, including understaffing.

94. Before Defendants fired Plaintiff, they provided her no verbal or written, formal or informal counseling or warning about supposed performance deficiencies.

95. AURORA's termination of Plaintiff was inconsistent with its progressive discipline policy, which begins with informal or formal counseling, followed by a verbal warning and then a written warning.

96. Upon information and belief, Defendants AURORA and SIGNATURE individually and jointly participated in and approved the termination of Plaintiff.

97. Plaintiff's managers and superiors and Defendants' officers, directors, and/or managing agents were aware of Plaintiff's protected activities recited previously and fired her because of those activities. Defendants relied on the recommendations provided by and reasons held by Plaintiff's managers and superiors and Defendants' officers, directors, and/or managing agents in terminating Plaintiff.

98. Upon information and belief, AURORA CEO Susan Rose received the approval, endorsement, and authorization of SIGNATURE executives Blair Stam and Michael Sherbun to fire Plaintiff.

99. Susan Rose, Michael Sherbun, and Blair Stam are or were officers, directors,

and/or managing agents of both Defendants and acted on behalf of Defendants with respect to the adverse actions against Plaintiff. Jointly and individually, they exercised substantial independent authority and judgment in their corporate decision making through their participation in and approval of the termination of Plaintiff.

100. Officers, directors, and/or managing agents of Defendants authorized, approved of, and ratified the termination of Plaintiff and/or approved of it after it occurred.

101. Following her termination, Plaintiff received a letter from the CDPH in response to her online complaint, informing her that "the outcome of the investigation is that L&C has substantiated your complaint. The basis for this finding is as follows: L&C validated the complaint allegation during the onsite visit."

102. Upon information and belief, on or about December 5, 2016, the Centers for Medicare and Medicaid Services issued to AURORA a "Statement of Deficiencies and Plan of Correction" regarding Plaintiff's CDPH complaint (CA00508731) and other complaints.

103. Upon information and belief, as a result of the investigation ensuing from Plaintiff's complaint, one of the Hospital's four operational units was temporarily shut down by state and federal authorities until the Hospital could increase its staffing to safely monitor the patient population.

104. Upon information and belief, SIGNATURE continued to prioritize the opening of a fifth unit and in early 2017, it admitted patients into the fifth unit even though it did not have enough staff to sustain the unit.

i. AURORA Lied to Plaintiff to Recruit Her to the Hospital

105. Before joining AURORA, from about April 2014 to about March 2016, Plaintiff was Chief Nursing Officer of HCA Dominion Hospital in Falls Church, Virginia.

106. On or about February 2, 2016, while Plaintiff was still employed as Chief Nursing Office at HCA Dominion Hospital, she was contacted by AURORA's HR Director Al Jennings about AURORA's search for a CNO in Santa Rosa. At HCA in Virginia, Plaintiff received an annual salary of about $157,000, an industry-standard annual bonus of about $30,000, restricted

stock unit grants, and high-quality health insurance consistent with her leadership role.

107. On February 9, 2016, Plaintiff had a phone call with Mr. Jennings about the CNO role at AURORA. Mr. Jennings told Plaintiff that he had worked at AURORA for years and described his time there as "great." He did not mention any high turnover of C-level and director-level staff. When Plaintiff learned from Mr. Jennings that AURORA offered a base salary lower than what she was earning at HCA, Plaintiff made a point of finding out the rest of the CNO compensation package from Mr. Jennings. Plaintiff felt that if she were to accept a salary cut to move to AURORA, then the Company's benefits package would be a critical factor in her decision. She emphasized the importance of a strong benefits package to Mr. Jennings, describing to him in detail her health insurance at HCA. Plaintiff stated that she had really good health insurance at HCA, that she had good short and long-term disability coverage, that she was on a PPO plan for which she paid hardly anything out of pocket, with a monthly premium of under $150 per month. She asked how AURORA's benefits compared to HCA's. Mr. Jennings responded to Plaintiff that AURORA's benefits were better than most and the same as or better than those she had at HCA. Mr. Jennings also went on to highlight AURORA's other assets, including stating that patients enjoyed the use of a swimming pool and that the Hospital's facility was new.

108. Plaintiff had no reason to question Mr. Jennings further about AURORA's benefits, because his assurances were clear and made sense. She reasonably expected and understood that AURORA would offer high quality health benefits comparable to HCA, especially to executive-level candidates, in order to be competitive.

109. On or about February 15, 2016, Plaintiff made an on-site visit to AURORA. The visit was highly structured with a tight schedule, consisting largely of brief, one-way interviews during which Plaintiff was asked questions but was unable to ask many of her own. When Plaintiff asked to speak with AURORA'S previous CNO, she was told she was not there. During her visit, nobody indicated that AURORA was at all unstable or in trouble of any kind. Plaintiff was led to believe that she would have job security should she accept the CNO position.

Plaintiff made it clear to AURORA that she was only interested in moving to Santa Rosa if this position would be the last big move of her career.

110. With these representations, Plaintiff accepted the CNO position at AURORA in late February 2016. In or about April 2016, Plaintiff moved from Virginia to California. Plaintiff began work at AURORA on May 2, 2016.

111. In or about her first week at AURORA, however, Plaintiff learned the particulars of the Hospital's standard health benefits. Contrary to Mr. Jennings's representations, Plaintiff's health benefits at AURORA were markedly inferior to her benefits at HCA, which Plaintiff had described in detail to Mr. Jennings. At AURORA, Plaintiff would be expected to pay a much higher premium than at HCA—over $500 per month—with a higher deductible, higher copay, and less coverage, including no coverage for disability. Plaintiff's benefits at AURORA were so inferior that she declined to enroll and instead relied on COBRA continuation coverage from her former employer, at great personal expense.

112. Additionally, shortly after she started work at AURORA, upon information and belief, Plaintiff learned that the Company was in the midst of a potential acquisition and could be sold in a matter of months. This was never disclosed to Plaintiff during her recruitment discussions with Mr. Jennings or others, nor was Plaintiff informed of the high rate of turnover among AURORA's C-level and director-level employees over the Hospital's few years in operation. By the time Plaintiff arrived, AURORA was on its third CEO and seventh CFO since opening in 2013. No mention of the rate of turnover within management was made to Plaintiff before she joined AURORA. Further, Plaintiff learned of other exaggerations during the recruitment process, including, for example, that the swimming pool touted by Mr. Jennings was in fact not usable by patients and that the Hospital's facility was not new but rather recently partially renovated.

First Cause of Action

Wrongful Termination in Violation of Public Policy

113. Plaintiff incorporates by reference the allegations contained in the foregoing

paragraphs of this complaint as if fully set forth herein.

114. Under California law, no employee can be terminated for a reason that violates a fundamental public policy.

115. It is against the public policy of the State of California to discharge or discriminate against employees for making any oral or written health and/or safety complaint or complaint regarding working conditions to a governmental agency or their employer. *See* Cal. Labor Code § 6310.

116. It is against the public policy of the State of California to discriminate or retaliate against employees of health facilities for presenting a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or to the medical staff of the facility, or to any other governmental entity. *See* Cal. Health and Safety Code § 1278.5.

117. It is against the public policy of the State of California to discriminate or retaliate against employees of health facilities for initiating, participating in, or cooperating in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that is carried out by a governmental entity or an entity or agency responsible for accrediting or evaluating the facility or its medical staff. *See* Cal. Health and Safety Code § 1278.5.

118. It is against the public policy of the State of California to retaliate against an employee for disclosing information, or because the employer believes that the employee disclosed or may disclose information, to a government or law enforcement agency, to a person with authority over the employee or another employee who has the authority to investigate, discover, or correct the violation or noncompliance. *See* Cal. Labor Code § 1102.5(b).

119. It is against the public policy of the State of California to retaliate against an employee for providing information to, or testifying before, any public body conducting an investigation, hearing, or inquiry, if the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or a violation of or noncompliance

with a local, state, or federal rule or regulation. *See* Cal. Labor Code § 1102.5(b).

120. It is against the public policy of the State of California to retaliate against an employee for refusing to participate in an activity that would result in a violation of state or federal statute, or a violation or noncompliance with a state or federal rule or regulation. *See* Cal. Labor Code § 1102.5(c).

121. Defendants AURORA and SIGNATURE are required to ensure, sufficient nursing care based on patient needs, pursuant to Title 22 of the Cal. Code of Regulations, §§ 71213 et seq.

122. Defendants AURORA and SIGNATURE are required to provide a safe and healthful workplace for employees, pursuant to Cal. Labor Code §§ 6400 et seq.

123. The termination of Plaintiff's employment was motivated by Plaintiff's making of oral and written complaints regarding health and safety conditions affecting patients and employees and working conditions to her employers, the Defendants, and to government agencies.

124. The termination of Plaintiff's employment was motivated by Plaintiff's disclosure of information to government agencies, to her employers, and to public bodies conducting investigation and inquiry, with Plaintiff having reasonable cause to believe that the information disclosed a violation of state or federal statutes and regulations governing psychiatric hospitals and occupational health and safety, such as those cited above.

125. The termination of Plaintiff's employment was motivated by Defendants' belief that in the future Plaintiff might disclose to government agencies or to her employers information about the Hospital's insufficient staffing and resources and other information indicating noncompliance with patient health and safety, patient rights, public health standards, and workplace health and safety standards.

126. The termination of Plaintiff's employment was motivated by Plaintiff's refusal to participate in activities that would result in a violation or noncompliance with statutes and regulations governing psychiatric hospitals and occupational health and safety, such as those

cited above.

127. The termination of Plaintiff's employment was motivated by Plaintiff's refusal to discipline or penalize staff who complained about overwork or health and safety issues.

128. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

129. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic damages related to her termination.

130. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proven at trial.

131. The conduct of Defendants described above was outrageous and was executed with malice, fraud, and oppression, and with conscious disregard for Plaintiff's rights. Defendants acted with the intent and purpose of injuring Plaintiff and deterring other employees from undertaking protected activities in furtherance of the rights of employees and patients.

132. Plaintiff is entitled to recover nominal, actual, compensatory, punitive, and exemplary damages in amounts to be proved at trial, in addition to any other remedies and damages allowable by law.

Second Cause of Action

Retaliation in Violation of Cal. Labor Code § 6310

133. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

134. Plaintiff engaged in the protected activities as described in detail in this Complaint, including:

a. Made a written complaint to California Department of Public Health ("CDPH") regarding unsafe working conditions;

b. Advocated internally for the rights of staff to safe working conditions;

c. Opposed directives and pressures from her superiors to increase admissions,

open the fifth unit, and limit labor expenditures, that compromised the rights of staff and patients to health and safety;

d. Refused to discipline or penalize staff who complained about workplace health and safety;

e. Refused to support admission of patients that the facility could not safely care for;

f. Took actions including capping admissions and hiring travel nurses to prioritize improving staffing above increasing patient census, in opposition to directives and pressures from Defendants;

g. Disclosed truthful but negative information about the Hospital to government investigators about staffing and health and safety problems.

135. In retaliation, Defendants fired Plaintiff.

136. Plaintiff's protected activities were, on their own and collectively, substantial motivating reasons for Defendants' decision to fire Plaintiff.

137. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

138. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic damages related to her termination.

139. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

140. Plaintiff is entitled to general compensatory, economic, and non-economic damages in amounts to be proven at trial.

141. The conduct of Defendants described above was outrageous and was executed with malice, fraud, and oppression, and with conscious disregard for Plaintiff's rights. Defendants acted with the intent and purpose of injuring Plaintiff and deterring other employees from undertaking protected activities in furtherance of the rights of employees and patients.

142. Plaintiff is entitled to recover punitive and exemplary damages in amounts to be proved at trial, in addition to any other remedies and damages allowable by law.

143. Plaintiff has been damaged and seeks civil penalties and attorneys' fees and costs against Defendants pursuant to Cal. Labor Code Sections 2699 and 2699.3.

Third Cause of Action

Retaliation in Violation of Cal. Health & Safety Code § 1278.5

144. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

145. In violation of Health and Safety Code § 1278.5, Defendants terminated Plaintiff's employment because Plaintiff made oral and/or written complaints regarding health, safety and/or working conditions to Defendants, to agencies responsible for accrediting or evaluating the facility, to the medical staff of the facility, and to governmental entities.

146. In violation of Health and Safety Code § 1278.5, Defendants terminated Plaintiff's employment because Plaintiff initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that was carried out by an entity or agency responsible for accrediting or evaluating the facility or its medical staff, or a governmental entity.

147. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

148. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic damages related to her termination.

149. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

150. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proven at trial.

151. The conduct of Defendants described above was outrageous and was executed

with malice, fraud, and oppression, and with conscious disregard for Plaintiff's rights. Defendants acted with the intent and purpose of injuring Plaintiff and deterring other employees from undertaking protected activities in furtherance of the rights of employees and patients.

152. Plaintiff is entitled to recover punitive and exemplary damages in amounts to be proved at trial, in addition to any other remedies and damages allowable by law.

Fourth Cause of Action

Retaliation in Violation of Cal. Labor Code § 1102.5

153. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

154. Defendants believed that Plaintiff had disclosed to the California Department of Public Health ("CDPH") information about the Hospital's insufficient staffing and resources and other information indicating noncompliance with patient health and safety, patient rights, public health standards, and workplace health and safety standards.

155. Defendants believed that in the future Plaintiff might disclose information indicating noncompliance with patient health and safety, patient rights, public health standards, and workplace health and safety standards to government agencies or accreditation agencies.

156. Plaintiff in fact disclosed to government and accreditation agencies information about the Hospital's inadequate staffing and resources and other truthful information indicating noncompliance with patient health and safety, patient rights, public health standards, and workplace health and safety standards. Plaintiff in fact made a written complaint to the CDPH, as detailed above.

157. Plaintiff disclosed to her employers information about staffing conditions insufficient to meet patient needs, advocated internally for the rights of staff to safe working conditions, and made recommendations to her employers for health and safety measures.

158. Plaintiff made such disclosures and recommendations and advocated for health and safety measures to those employees and officers within AURORA and SIGNATURE with authority to investigate, discover, and correct noncompliance.

159. Plaintiff had reasonable cause to believe that the information she provided to internal and external recipients disclosed violations of state and federal rules and regulations.

160. Plaintiff also:

a. Opposed directives and pressures from her superiors to increase patient admissions or reduce labor expenses;

b. Refused to fire staff who complained about workplace health and safety;

c. Refused to support admission of patients that the facility could not safely care for; and

d. Had reasonable cause to believe that supporting and participating in these activities and decisions would result in violations of state and federal rules and regulations and violate her ethical duties as a nurse.

161. In retaliation, Defendants fired Plaintiff.

162. Plaintiff's disclosures and refusals to participate were, on their own and collectively, substantial motivating and contributing factors in Defendants' decision to fire her.

163. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

164. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic damages related to her termination.

165. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

166. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proven at trial.

167. The conduct of Defendants described above was outrageous and was executed with malice, fraud, and oppression, and with conscious disregard for Plaintiff's rights. Defendants acted with the intent and purpose of injuring Plaintiff and deterring other employees from undertaking protected activities in furtherance of the rights of employees and patients.

168. Plaintiff is entitled to recover punitive and exemplary damages in amounts to be proved at trial, in addition to any other remedies and damages allowable by law.

169. Plaintiff has been damaged and seeks civil penalties and attorney fees and costs against Defendants pursuant to Cal. Labor Code Sections 2699 and 2699.3.

Fifth Cause of Action

Solicitation of Employee by Misrepresentation In Violation of Cal. Labor Code § 970

170. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

171. Defendants, through AURORA's Human Resources Director, represented to Plaintiff the following terms and conditions of employment and workplace conditions:

a. AURORA was a new facility;

b. AURORA was a stable company offering a stable, long-term employment opportunity;

c. AURORA's employee benefits were better than those of most industry employers; and

d. AURORA's health benefits and bonuses were just as good as or better than at HCA, her employer at the time. Plaintiff had recited the specifics of her health benefits at HCA and told him about the bonuses she earned at HCA. AURORA's Human Resources Director said AURORA offered the same or better.

172. Defendants knew that these representations were false.

173. Defendants had superior knowledge of the true facts and knew that Plaintiff would rely on their representations and have no reason to doubt their representations. Defendants failed to disclose the full, true facts when doing so was necessary to avoid a misrepresentation. Defendants concealed material facts which they had a duty to disclose.

174. Defendants used misrepresentations to induce Plaintiff to change her employment and move to California, a result Defendants could not have achieved had they been truthful.

175. Defendants intended that Plaintiff rely on the representations as set forth herein.

176. In reliance on the representations and in ignorance of the falsity thereof, Plaintiff resigned from her job as CNO with HCA and changed her place of residence by moving from Virginia to Santa Rosa, California for the purpose of working for Defendants as CNO at the Hospital.

177. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

178. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic losses as a result of her resignation from her job at HCA, relocation to California, and wrongful termination from the AURORA Hospital.

179. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

180. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proved at trial.

181. Plaintiff is entitled to double damages pursuant to Labor Code § 972.

182. Plaintiff seeks civil penalties and attorney fees and costs against Defendants pursuant to Cal. Labor Code Sections 2699 and 2699.3.

Sixth Cause of Action

Intentional Misrepresentation

183. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

184. In making the representations related to employment as CNO in the AURORA Hospital, Defendants made misrepresented material facts affirmatively and by omission, with the intention of inducing Plaintiff to rely on such misrepresentations.

185. Defendants knew that the representations were false or made the representations in reckless disregard for their truth.

186. Plaintiff had no reason to believe that the representations were false. In reliance thereon, Plaintiff resigned from her job with HCA in Virginia and relocated to California.

187. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

188. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic losses as a result of her resignation from her job at HCA, relocation to California, and wrongful termination from the AURORA Hospital.

189. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

190. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proved at trial.

191. The conduct of Defendants described above was outrageous and was executed with malice, fraud, and oppression, and with conscious disregard for Plaintiff's rights. Defendants acted with the intent and purpose of injuring Plaintiff and causing Plaintiff to relinquish valuable property, benefits, and stability.

192. Plaintiff is entitled to recover punitive and exemplary damages in amounts to be proved at trial, in addition to any other remedies and damages allowable by law.

Seventh Cause of Action

Negligent Misrepresentation

193. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

194. When AURORA's Human Resources Director made the aforementioned representations, he did not have reasonable ground for believing them to be true. The representations were made with the intent to induce Plaintiff to leave her position at HCA and relocate to Santa Rosa.

195. Plaintiff was unaware of the falsity of the representations, acted in reliance upon

the truth of the representations, and was justified in relying upon such representations.

196. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer pain and mental anguish and emotional distress.

197. As a direct and proximate result of the actions of Defendants, Plaintiff has suffered and will continue to suffer a loss of earnings, other employment benefits, and other economic losses as a result of her resignation from her job at HCA, relocation to California, and wrongful termination from the AURORA Hospital.

198. Plaintiff has also incurred and continues to incur attorneys' fees and legal expenses in an amount to be proved at trial.

199. Plaintiff is entitled to general compensatory, economic and non-economic damages in amounts to be proved at trial.

Eighth Cause of Action

Private Attorneys General Act Enforcement

200. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

201. Plaintiff is an aggrieved employee of Defendants within the meaning of Labor Code § 2699(c).

202. On or about June 19, 2017, Plaintiff filed a letter with the California Labor and Workforce Development Agency pursuant to the Private Attorneys General Act, Labor Code § 2699.3. Plaintiff's June 19, 2017 letter to the LWDA is attached hereto as Exhibit A. Plaintiff incorporates by reference the contents of Exhibit A. In her letter, Plaintiff described violations of unlawful retaliation under Cal. Lab. Code §§ 1102.5(a)-(d), 1198.5, and Cal. Lab. Code Sections 6310 and 6311. Plaintiff served this letter on Defendants AURORA and SIGNATURE via certified mail.

203. On or about November 1, 2017, Plaintiff filed a second letter with the California Labor and Workforce Development Agency pursuant to the Private Attorneys General Act, Labor Code § 2699.3. Plaintiff's November 1, 2017 letter to the LWDA is attached hereto as

Exhibit B. Plaintiff incorporates by reference the contents of Exhibit B.

204. Through her second letter, Plaintiff provided notice that Defendants' confidentiality policies and practices violated Labor Code § 232.5, that Defendants failed to provide meal and rest breaks as Required by Cal. Lab. Code Sections 512, 226.7 and 1998 and IWC Wage Order No. 5-2001, that Defendants failed to provide suitable seats for employee use as required by Labor Code Section 1198 and IWC Wage Order No. 5-2001, and that Defendants maintained unsafe and unhealthy workplace conditions in violation of violations of Labor Code Sections 6400, 6401, 6401.7, 6401.8, 6402, 6403, 6403.5, 6405, and 6406 as well as implementing rules, regulations and orders under 6407. Plaintiff also informed the LWDA that Defendants misrepresented material facts about the terms and conditions of her employment in violation of Labor Code § 970.

205. To submit the above-referenced two letters to the LWDA as required by Section 2699.3, Plaintiff utilized the mandatory online filing system of the LWDA and followed the instructions therein, including the instruction that "Filing an item with the LWDA through this online system also constitutes filing with the Division of Occupational Safety and Health ("Cal-OSHA") of any notice or other document required to be filed with that agency pursuant to subdivision (b) of Labor Code Section 2699.3."

206. As to those violations subject to Labor Code § 2699.3(a), Plaintiff has satisfied the pre-filing requirements. Through her two letters described above, she gave written notice to the LWDA by online filing and to the employers by certified mail of the specific provisions listed within § 2699.5 that she alleges were violated, including the facts and theories to support the violations. Plaintiff submitted the required filing fee. More than 65 days have passed since the postmark date of certified mail notice and the LWDA has given no notice to Plaintiff regarding its intention to investigate.

207. As to those violations subject to Labor Code § 2699.3(b), Plaintiff has satisfied the pre-filing requirements. Through her two letters described above, she gave written notice to Cal-OSHA by online filing and to the employers by certified mail of the specific provisions of

the specific provisions of Division 5 (commencing with Section 6300) alleged to have been violated, including the facts and theories to support the violations.

208. All of the timeframes set forth in Labor Code § 6309 have passed. To date, Plaintiff has not received any information from Cal-OSHA indicating that Cal-OSHA has taken any action, initiated an investigation, conducted an inspection, or issued a citation in regard to Plaintiff's allegations of health and safety violations. Therefore, and upon information and belief, Plaintiff alleges that Cal-OSHA failed to inspect or investigate the alleged violations.

209. As to those violations subject to Labor Code § 2699.3(c), Plaintiff has satisfied the pre-filing requirements. Through her two letters described above, she gave written notice to LWDA, Cal-OSHA, and the employers. Several months have passed and she has received no notice of an attempt to cure the violations. Therefore, and upon information and belief, Plaintiff alleges that Defendants have not attempted to use the notice-and-cure provisions of Section 2699.3.

210. Plaintiff has incurred and continues to incur attorneys' fees and legal expenses to prosecute the Labor Code violations.

211. On behalf of the State of California, for violations experienced by current and former employees of Defendants as specified in her letters to the LWDA, Plaintiff seeks to recover civil penalties, to end ongoing violations, and to deter future violations through this PAGA representative action. She is entitled to an award of civil penalties, attorneys' fees and costs, and permanent injunctive relief pursuant to, inter alia, the PAGA, Civil Code § 3422, and the Court's equitable powers.

Ninth Cause of Action

Injunctive Relief Pursuant to California Business & Professions Code §§ 17200, et seq. - Unlawful and Unfair Business Practices

212. Plaintiff incorporates by reference the allegations contained in the foregoing paragraphs of this complaint as if fully set forth herein.

213. Defendant engaged in unlawful business practices or acts in violation of Business

& Professions Code §17200, et seq., both as to Plaintiff and as to other current and former employees. By engaging in the above-described conduct, Defendants have violated the California Labor Code and Health & Safety Code as well as other California statutes and regulations.

214. Defendants' conduct constituted unfair business practices and acts because the harm to patients, employees, and Plaintiff outweighed any utility that each Defendant's conduct may have produced. Defendants' conduct also constituted unfair business practices and acts because its practices have been immoral, unethical, oppressive, unscrupulous, and/or substantially injurious to their patients, employees and Plaintiff.

215. The harm to the general public has been patients and employees being subjected to unsafe and unhealthy conditions at the Hospital and employees being subjected to fear of retaliation and policies that require confidentiality and suppression of disclosures of information regarding health and safety violations and working conditions. The utility of Defendant's conduct comes from the profit and pecuniary gain achieved from increasing patient census, minimizing labor costs and neglecting necessary safety improvements in its facility and operations.

216. Defendants have engaged in unlawful, unfair and deceptive business practices with respect to their solicitation of Plaintiff to the CNO position at AURORA.

217. Plaintiff lost money or property as a result of Defendants' unlawful, unfair, and fraudulent business practices.

218. Plaintiff seeks injunctive and affirmative relief to curtail and prevent ongoing and future unfair and unlawful business practices and an award of attorneys' fees and costs pursuant to Code of Civil Procedure § 1021.5.

PRAYER FOR RELIEF

WHEREFORE Plaintiff prays for judgment and relief as follows:

1. General economic and non-economic damages according to proof;

2. Special damages according to proof;

3. Punitive damages according to proof;

4. Civil penalties under the California Labor Code;

5. Permanent injunctive relief, including but not limited to:

a. an injunction restraining Defendants from continuing or maintaining any policy, practice, custom or usage which is retaliatory in nature against any employee for the employee making a complaint related to health and safety of patients or employees or to prevent or discourage the employee from making such a complaint, or for the employee refusing to participate in conduct that the employee reasonably believed would jeopardize the health and safety of patients or employees;

b. an injunction restraining Defendants from continuing or maintaining any policy, practice, custom or usage which prevents or discourages employees from making disclosures or complaints to their employers or government agencies regarding their working conditions;

c. Affirmative relief requiring Defendants, and each of them, to notify all employees and supervisors, through individual letters and permanent posting in prominent locations in the Hospital in Santa Rosa, that retaliation violates California laws;

6. Reasonable attorneys' fees;

7. Costs of this suit;

8. Pre- and post-judgment interest; and

9. Such other and further relief as the Court deems just and proper.

JURY DEMAND

Plaintiff requests a jury on all causes of action triable by jury.

/ / /

/ / /

Respectfully submitted,

Dated: February 2, 2018

By: _____

Xinying Valerian, Esq.
VALERIAN LAW

Qiaojing Zheng, Esq.
SANFORD HEISLER SHARP, LLP

Attorneys for Plaintiff Teresa Brooke

Exhibit A

Sanford Heisler Sharp, LLP

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New York | Washington D.C. | San Francisco| San Diego | Nashville

June 19, 2017

VIA ONLINE FILING
Labor and Workforce Development Agency

Re: Labor Code Private Attorney General Act of 2004 – Notice on behalf of Teresa Brooke

Dear Labor and Workforce Development Agency:

This letter provides notice on behalf of Teresa Brooke ("Plaintiff"), a former employee of Aurora Behavioral Healthcare – Santa Rosa, LLC, a subsidiary of Signature Healthcare Services, LLC ("Aurora" or "the Company"), pursuant to the California Private Attorneys General Act of 2004, the Labor Code §2699.3. We request that the LWDA investigate violations of the Labor Code, including without limitation, Cal. Lab. Code section 1102.5(a)-(d), Cal. Lab. Code section 6310 and 6311, at Aurora. Aurora has also violated Cal. Lab. Code section 1198.5 by failing to produce Plaintiff's personnel file. We also request that the LWDA provide notice to Plaintiff through the undersigned legal counsel if it chooses not to investigate the allegations.

Aurora Behavioral Healthcare – Santa Rosa is one of a series of psychiatric hospitals owned by Signature Healthcare Services, a Michigan-based Limited Liability Company. Plaintiff worked for Aurora as a Chief Nursing Officer in Santa Rosa, California from May 2016 to November 2016, when she was terminated for complaining about and refusing to participate in company practices violating the California Code of Regulations ("CCR"), the California Occupational Safety and Health Act, and the California Health & Safety Code.

Aurora Maintains Nurse-to-Patient Staffing Ratios that Violate the California Code of Regulations and Create a Dangerous Environment for Hospital Staff and Patients

Title 22, Division 5, section 70217(a)(13) of the California Code of Regulations, implementing California Health & Safety Code section 1276.4 provides:

> (13) The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes of psychiatric units only, "licensed nurses" also includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed nurses on the unit.

Throughout Plaintiff's employment at the Company, Aurora failed to meet these minimum requirements and failed to make necessary staffing adjustments after Plaintiff repeatedly expressed concern regarding the facility's noncompliance. When she started work at Aurora, Plaintiff observed that only one or two licensed nurses were assigned to cover more than 19 patients. 22 CCR § 70217(a)(13) requires that psychiatric units maintain a nurse-to-patient ratio of 1:6 or fewer at all times. Aurora's nurse-to-patient ratio was more than 1:19 or worse at the start of Plaintiff's employment. This ratio fell even lower on nights and weekends, or when nurses called in sick.

Plaintiff immediately notified Aurora's leadership of the Company's violation of the regulation and began lobbying to improve its staffing ratios and other regulatory shortfalls. Then-CEO Kay Seim acknowledged the problem and supported Plaintiff's efforts. She allowed Plaintiff to hire travel nurses on a contractual basis to boost staff numbers temporarily. CEO Seim also granted Plaintiff latitude to limit patient admissions to a number the facility's staff was permitted to supervise under Title 22. Moreover, CEO Seim was supportive of Plaintiff's request that Aurora consider raising nurses' wages, which were significantly below the market rate, resulting in a high rate of attrition of hospital staff and an inability to meet staffing ratio requirements.

However, Plaintiff met significant resistance from the Company's management, including Aurora's then-Chief Financial Officer, Susan Rose, and Signature Healthcare Services Vice President of Clinical Operations, Michael Sherbun. CFO Rose and VP Sherbun, along with the Company's corporate leadership, ignored Plaintiff's requests to ensure compliance with California Health and Safety Code and accompanying regulations, and continued to insist that the facility increase patient admissions and lower staffing costs. The Company's leadership disregarded Plaintiff's complaints and emails and dodged her requests to meet in person to discuss the need for additional staff. Moreover, they pressed to open an additional unit at the Company's Santa Rosa facility, despite their awareness of these glaring staff deficiencies.

Due to this resistance from the Company's management, Plaintiff was unable to hire more permanent staff or cap patient admissions. The hospital remained noncompliant with the staffing ratios required by law. Conditions for patients and staff deteriorated. Throughout the summer and early fall of 2016, the facility's insufficient and illegal staffing exhausted Aurora's nurses, many of whom were forced to work 16-hour shifts and miss meal periods to make up for personnel shortages. This resulted in regular injuries to staff. Losing nurses to injuries and medical leave only exacerbated staffing deficiencies. Additionally, understaffing during this period led to a series of injuries and violent incidents among patients, who were chronically under-supervised. The situation went from merely noncompliant to dangerous.

Plaintiff continued to complain to the Company's leadership. She discussed the understaffing problem on a weekly basis with CEO Seim in one-on-one meetings and regularly expressed concern to all C-level directors at routine "flash meetings." Following patient and staff incidents throughout the fall, Plaintiff met with the Company's HR to reiterate her complaints. In one instance, after another nurse sent an email to management expressing concern about staffing shortages, Plaintiff broached the issue with CFO Rose, who suggested that nurse should be fired for complaining. Throughout October 2016, Plaintiff attempted to meet in person with VP

Sherbun to discuss a solution, but he avoided her. All the while, the Company's leadership continued to press for the opening of a new unit.

Aurora Retaliated Against Plaintiff for Complaining of the Company's Noncompliance to Company Management and to the California Department of Public Health, In Violation of Cal. Lab. Code Section 1102.5 (a-d), and Cal. Lab. Code section 6310 and 6311.

On October 27, 2016, the Company abruptly fired CEO Seim. Upon information and belief, her termination was a result of her efforts to support Plaintiff's efforts to blow the whistle on the Company's illegal practices, bring the Company into compliance, and resist the opening of an additional hospital unit that would only exacerbate the problem.

After it fired CEO Seim, the Company selected Susan Rose as the new CEO. Ms. Rose had staunchly resisted Plaintiff's and CEO Seim's efforts to hire more staff and had aggressively pushed to open the additional unit. In her first days as Aurora's CEO, Ms. Rose immediately reversed Plaintiff's efforts, several months in the making, to mitigate the staffing shortages. Ms. Rose suspended the use of travel nurses and divested Plaintiff of the authority to overrule the Administrator-On-Call on patient admission decisions. Seizing that authority for herself, Ms. Rose pushed to maximize the number of patients admitted, even though she knew this would exacerbate the facility's noncompliance and risk further injuries to the patients and staff.

Plaintiff had lost her only ally at the Company, and was unable to stand by as the Company continued its unlawful operations. To ensure that the Company ceased its illegal practices and improve the unsafe working conditions at Aurora, Plaintiff filed a complaint with the California Department of Public Health ("CDPH") at the end of October 2016. In her CDPH complaint, Plaintiff detailed Aurora's staffing deficiencies, unsafe working conditions, and endemic noncompliance with California law.

On November 17, 2016, the CDPH's Licensing & Certification Program made an unannounced visit to Aurora to investigate Plaintiff's claims. CDPH substantiated and validated Ms. Brooke's complaint and instructed Aurora to close one of its four operational units.

In retaliation against Plaintiff's whistleblower complaint to the CDPH, Aurora terminated her employment on November 25, 2016, one week after the surprise CDPH visit.

Aurora's explanation for terminating Plaintiff was plainly pretextual. The Company wrote on Plaintiff's notice of termination that her "performance did not meet expectations." This is simply not true. Plaintiff was a high performing employee who, in her only performance evaluation, received a glowing review before her engagement in protected activities. Ms. Brooke was not terminated for performance issues. Rather, the Company targeted her for termination upon learning of her CDPH complaint, one that was meant to bring the facility into compliance with state statutes and regulations, protect patients, and ensure safe working conditions for staff at Aurora.

Aurora Failed To Produce Plaintiff's Personnel File

Plaintiff's counsel has requested that the Company produce Plaintiff's personnel file on several occasions but has received no response from the Company. In a letter addressed to Ms. Rose and received via Federal Express on May 3, 2017, Plaintiff's counsel requested that the Company produce her personnel file. The Company has neither responded nor complied with the request. Plaintiff's counsel had previously sent the same letter to the Agents for Service of Process for both Aurora Behavioral Healthcare – Santa Rosa and Signature Healthcare Services, LLC (received via Federal Express on April 25, 2017 and April 27, 2017, respectively). To date, neither entity has produced Plaintiff's personnel file.

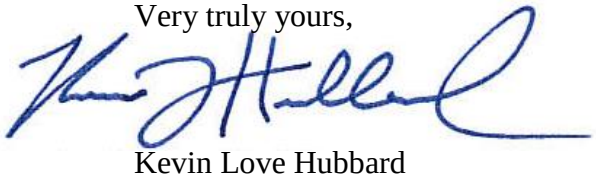
******

The Private Attorney General Act (Labor Code section 2698 et seq.) entitles an employee to recover civil penalties for violations of the Labor Code on behalf of herself and others. An employer that violates section 1102.5 is liable for $10,000 in civil penalties. An employer that violates section 6310 and 6311 is liable for $100 for each aggrieved employee per pay period for the initial violation and $200 for each aggrieved employee per pay period for each subsequent violation. Finally, an employer that violates section 1198.5 is liable for a penalty of $750. Plaintiff therefore makes this complaint on behalf of herself.

On behalf of our client, we request that the LWDA investigate the alleged violations, or provide timely notice to the undersigned if it chooses not to investigate the allegations.

Thank you for your attention to this matter.

Very truly yours,



Kevin Love Hubbard

CC: Aurora Behavioral Healthcare – Santa Rosa, LLC and Signature Healthcare Services, LLC, c/o Blair Stam, via certified mail.

Signature Healthcare Services, LLC, c/o Laura Sanders, via certified mail.

Aurora Behavioral Healthcare – Santa Rosa, LLC, c/o Susan Rose, via certified mail.

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Total		$3.84

Exhibit B

VALERIAN LAW

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Oakland, CA 94612

888-686-1918 • 510-982-4513 (F)
xinying@valerian.law

November 1, 2017

VIA ONLINE FILING
Labor and Workforce Development Agency
(and Division of Occupational Safety and Health)

Re: Labor Code Private Attorney General Act of 2004 – Supplemental Notice on behalf of Teresa Brooke (LWDA Case No. LWDA-CM-259213-17)

Dear Labor and Workforce Development Agency:

This letter supplements the June 19, 2017 notice to the LWDA and Cal-OSHA on behalf of Teresa Brooke ("Plaintiff"). Plaintiff was employed by Aurora Behavioral Healthcare – Santa Rosa, LLC and its corporate parent, Signature Healthcare Services, LLC (collectively "the Company"), pursuant to the California Private Attorneys General Act of 2004, the Labor Code § 2699.3.

Plaintiff's June 19, 2017 notice is attached and the allegations therein are incorporated herein. In addition to the violations in the June 19, 2017 notice, we request that the LWDA and Cal-OSHA investigate additional Labor Code violations stated herein. It is our understanding that based on LWDA operating protocols, our filing of the original notice and the supplemental notice through the LWDA's online system also constituted filing with the Division of Occupational Safety and Health (Cal-OSHA) pursuant to subdivision (b) of Labor Code Section 2699.3.

I. Background

Aurora Behavioral Healthcare – Santa Rosa ("Aurora") is one of a series of psychiatric hospitals owned by Signature Healthcare Services, a Michigan-based Limited Liability Company. Plaintiff worked for Aurora as a Chief Nursing Officer in Santa Rosa, California from May 2, 2016 to November 25, 2016, when she was terminated for complaining about, opposing, and refusing to participate in company practices violating the California Labor Code, California Code of Regulations, the California Occupational Safety and Health Act, and the California Health & Safety Code.

Upon information and belief, Signature Healthcare Services operates psychiatric hospitals in seven locations in California:

1. Santa Rosa (Aurora Behavioral Healthcare - Santa Rosa, LLC)
2. Covina Charter Oak Hospital, Aurora Charter Oak - Los Angeles, LLC)
3. Pasadena Las Encinas Hospital (Aurora Las Encinas, LLC)
4. Bakersfield Behavioral Healthcare Hospital (Bakersfield Behavioral Healthcare Hospital, , LLC)

5. San Diego (Aurora - San Diego, LLC)
6. Ventura, Aurora Vista Del Mar Hospital (Aurora Vista Del Mar, LLC)
7. Roseville (Aurora Behavioral Healthcare-Roseville, LLC)

While each of them organized is as an LLC and day to day operations are managed by an on-site management team, an executive team at Signature Healthcare provides centralized oversight and direction by setting the budget and corporate policies.

II. Throughout Signature Healthcare's Seven Psychiatric Facilities in California, the Company's Confidentiality Policies and Practices Violated Labor Code Section 232.5.

As a condition of employment, the Company required Plaintiff to enter into a confidentiality agreement. The agreement's broadly written provisions encompassed the confidentiality of information about employees and their working conditions. The agreement encompassed "human resources," "internal reporting," "communications," "employees" and "management information." As stated in the agreement, violation of the agreement may result in discipline, including termination.

As described above, Ms. Brooke reported the hospital's poor working conditions for nurses to CDPH. Based on her experiences throughout her employment and her firing after whistleblowing to the CDPH, Ms. Brooke alleges that the Company's confidentiality policy was enforced as a matter of corporate policy and practice, and daily corporate culture. The Company's conduct vis-à-vis Ms. Brooke violated Labor Code Section 232.5 subd. (a), (b), and (c).

The Company's confidentiality policies and practices were uniform for all employees and violated Labor Code Section 232.5 subd. (a) and (b). Upon information and belief, all employees of the above-named seven Aurora facilities in the State of California were subjected to the same requirements that they refrain from disclosing information that includes information about working conditions and all employees were required to sign the same confidentiality agreement.

Upon information and belief, all current and former employees are aggrieved by these violations of Section 232.5 subdivisions (a) and (b) and such violations are continuing and ongoing.

III. In Santa Rosa, the Company Failed to Provide Employees with Meal Breaks and Rest Periods As Required by Cal. Lab. Code Sections 512, 226.7 and 1998 and IWC Wage Order No. 5-2001.

After she began working at Aurora's Santa Rosa hospital, Plaintiff found that Aurora was out of compliance with California meal and rest break requirements specified by the California Labor Code and Industrial Welfare Commission Wage Orders (Cal. Lab. Code §§ 512, 226.7; IWC Order No. 5-2001, § 12). These violations are rooted in the hospital's ongoing understaffing and refusal to hire nurses and support staff sufficient to care for the volume of patients accepted by the facility.

Upon information and belief, before Plaintiff joined Aurora, it was commonplace for the hospital's nursing and auxiliary staff to miss meal and rest breaks guaranteed by law. This situation continued unabated during Plaintiff's employment. Upon information and belief, after Plaintiff's employment ended, nursing and auxiliary staff continued to be denied meal and rest breaks.

All current and former non-exempt employees in these positions are potentially aggrieved employees under PAGA. The meal and rest break violations are continuing and ongoing, upon information and belief.

In particular, nurses (e.g., RNs and LVNs), Licensed Psychiatric Technicians (LPTs) and mental health care workers often worked more than their 8-hour shifts of and would work 12-16 hours or more in a 24-hour period. It is well-known that errors increase when employees are over-worked.

Missed breaks typically went unreported because the Company's Corporate leadership and Aurora Santa Rosa's Chief Financial Officer, Susan Rose, discouraged non-exempt employees from recording them in order to save the hospital money. Thus, even as the employees were routinely forced to work through meal and rest breaks to care for patients or fulfill their job responsibilities, they were told to clock in and out as if they had, or else face retaliation.

As with the rampant understaffing at the facility, Aurora's leaders were aware of the extent of missed meal and rest periods. Plaintiff sought to combat the problem. From the beginning, she encouraged nurses and auxiliary staff to take their breaks as allowed by law and, failing that, to accurately report the breaks they had missed. She likewise addressed the issue at weekly and monthly meetings with Aurora's C-level leadership. In the process, Plaintiff faced opposition from Ms. Rose, who expressed to Plaintiff her belief that hospital staff was "lazy" and accused the staff of missing breaks in order to squeeze more money out of the Company.

Despite her efforts, Plaintiff could not eliminate the source of the problem—the hospital's refusal to hire and retain more staff and a drive to increase patient census.

IV. In Santa Rosa, the Company Failed to Provide Employees with Suitable Seats As Required by Labor Code Section 1198 and IWC Wage Order No. 5-2001.

California IWC Order No. 5-2001, Section 14 provides:

> (A) All working employees shall be provided with suitable seats when the nature of the work reasonably permits the use of seats.
>
> (B) When employees are not engaged in the active duties of their employment and the nature of the work requires standing, an adequate number of suitable seats shall be placed in reasonable proximity to the work area and employees shall be permitted to use such seats when it does not interfere with the performance of their duties.

The Santa Rosa facility did not comply with either of these subparts. The lack of suitable seating

affected all current and former nurses and auxiliary staff.

Throughout Plaintiff's employment and continuing to the present, the Aurora Santa Rosa facility has failed to provide seating suitable to the needs and numbers of its nursing and auxiliary staff. The job duties of these staff members include significant amounts of time filling out paperwork, updating charts, and maintaining files and documents. Aside from C-level employees and managers, who had their own private offices, the only workspaces available to nurses and auxiliary staff, who made up the vast majority of employees at the facility, were two tiny nurses' stations, each one connected to two of the facility's patient units.

These nurses' stations and the counter space within them were of a wholly inadequate size to allow nurses and auxiliary staff to complete their paperwork. While upwards of 20-25 staff might need to occupy each nurses' station on a typical day, spending up to 3-4 hours per day on paperwork, there were only 2-4 chairs in each station. Nurses and auxiliary staff were routinely forced to complete paperwork elsewhere: For instance, would sit on the facility's floors, find vacant seclusion rooms designated for patients' use, and even sit in the bathroom. Without enough seats or counter space, the staff were forced to do their charts in inappropriate, undignified and unsanitary locations.

Violations of the Section 14 seating requirements existed throughout Plaintiff's employment and, upon information and belief, are ongoing.

V. In Santa Rosa, Numerous Unsafe and Unhealthy Workplace Practices and Conditions Were Rampant and Persist

Plaintiff observed unsafe and unhealthy workplace conditions throughout her employment at Aurora. These conditions constituted violations of Labor Code Sections 6400, 6401, 6401.7, 6401.8, 6402, 6403, 6403.5, 6405, and 6406 as well as implementing rules, regulations and orders under 6407. In toto, the unsafe and unhealthy conditions resulted in staff suffering preventable injuries and created a work environment rife with risks to the staff.

a. Understaffing, Resulting In High Rates of Injury to Staff and Patients.

As alleged in detail in the June 19, 2017 notice, the Santa Rosa facility was understaffed, resulting in abnormally high rates of injury to both staff and patients in violation of Labor Code Sections 6400, 6401, 6402, 6403, 6404, 6406, and 6407.

b. Insufficient and Overcrowded Nurses' Stations

Throughout Plaintiff's employment at Aurora Santa Rosa, and continuing today, the design of the hospital facility has resulted in unsafe working conditions for Aurora's nursing and auxiliary staff in violation of Labor Code §§ 6400, 6401, 6402, 6403, 6404, 6406, and 6407. At the time of Plaintiff's employment, the hospital contained four patient units. These units were supervised by a total of two nurses' stations, with two sets of two units supervised by a single nurses' station. The nurses' stations were small, approximately 10 x 12 feet. Between nurses, mental health workers, and other auxiliary staff, anywhere between 20 to 25 employees were expected to utilize

the nurses' station at any given time.

From these stations, nurses and auxiliary staff are expected to complete paperwork and charting responsibilities, administer medications, and supervise upwards of nearly 40 patients. However, these small units are so overcrowded and cramped that staff were unable to safely execute their job responsibilities. Aggravated by the facility's chronic understaffing, the design of these nurses' stations resulted in inadequate supervision of patients and increased risk of injury to both patients and staff.

These conditions are an ongoing and current risk to all Aurora nurses and auxiliary staff.

c. Unsafe Placement of Seclusion/Restraint Rooms Inside Nurses' Stations

Compounding the poor design of the nurses' stations was the location of restraint rooms inside the stations themselves. The purpose of restraint rooms in mental health facilities such as Aurora is to provide a safe place for patients exhibiting violence where they will not cause harm to other patients or hospital staff. It is highly unorthodox to locate such rooms within the nurses' stations of a unit. In Plaintiff's decades of experience in her profession, she has never before seen such an arrangement.

The design and placement of restraint rooms at Aurora creates an unsafe environment. Except when brought to the restraint room, patients are never permitted to enter the nurses' stations. When patients exhibiting violent and dangerous behavior are brought into the restraint rooms at Aurora, they must be walked into and through the cramped nurses' stations, coming within inches of computers, pens, scissors, and other supplies that could cause serious harm to staff and other patients.

Upon information and belief, the placement of restraint rooms within the nurses' stations constitute an ongoing safety risk to all Aurora nurses and auxiliary staff. All current and former nurses and auxiliary staff working in the vicinity of the nurse stations have been subjected to this unsafe work environment in violation of Labor Code §§ 6400, 6401, 6402, 6403, 6404, 6406, and 6407.

d. Unsafe Administration of Medication

At Aurora Santa Rosa, the distribution of medication takes place at the nurses' stations through a window in each station, creating unsafe conditions in violation of Labor Code §§ 6400, 6401, 6402, 6403, 6404, 6406, and 6407. In most hospitals, based on Plaintiff's extensive experience, an entirely separate room is reserved for the administration of medication to patients. Such an arrangement would enable personnel to administer medication in a way that protects the privacy for the patients, protects physical safety of staff and patients, and allows the substances to be distributed in a careful and non-hurried manner to patients at the appropriate time.

The design of the Aurora Santa Rosa hospital, however, does not permit privacy, safety, or careful distribution of medication. There is no separate room, just the overcrowded and busy nurses' stations. Distribution of medication occurs in the midst of a variety of activities in the

nurses' stations. Consequently, the risks of inaccurate distribution skyrocket. As nurses attempt to dispense medicine through a window in the station, patients often try to reach through the window and grab handfuls of other patients' medications. Administering medication from the chaotic environment of the nurses' station increases the risks that patients or staff might be hurt in the process.

Additionally, this system of administering medications resulted in Aurora's failure to comply with privacy requirements under HIPAA, as other patients were readily able to hear what medicines their peers were receiving.

Upon information and belief, the improper system for Aurora's administration of medication cause ongoing and current safety risks to all Aurora nurses, auxiliary staff, and patients.

e. Failure to Provide Sufficient Hand Washing and Sanitizing Stations

Throughout Plaintiff's employment and, upon information and belief, continuing to today, Aurora Santa Rosa lacks sufficient hand washing stations and sinks for staff use, in violation of Labor Code §§ 6400, 6401, 6402, 6403, 6404, 6406, and 6407.

Aurora maintains one sink at the back of each of the facility's two nurses' stations, one sink in one of the facility's restraint rooms, one sink in each of the four units' refreshment areas, one sink in each of the facility's two medication rooms, and one sink in each patient room. However, out of these handwashing areas, only the two nurses' stations sinks and the sinks in the refreshment areas are readily available and accessible for use by staff. The restraint room sink and medication room sinks were generally inaccessible, as those rooms were kept locked unless a patient was in restraint or medication was being retrieved. Similarly, the sinks in patient rooms were restricted for patient use, and staff could not realistically or safely access them. This dearth of sinks created an unnecessary health risk to patients and staff.

After Plaintiff began working at Aurora and noticed the dangerous lack of handwashing stations, she attempted to improve safety by increasing hospital-wide use of hand sanitizers. At the time she started, Aurora had hand sanitizer available only through dispensers on the walls of the facility's two nurses' stations. Plaintiff ensured that dispensers were added to the hallways outside of the patient areas (to allow for sanitization immediately upon leaving the units) and to the facility's portable blood pressure and vital measurements machines (to allow for staff sanitization between patient examinations). She also encouraged staff to keep and regularly use miniature hand sanitizer bottles, but these steps could not undo the risk created by the hospital's sink shortage.

Upon information and belief, all current and former nursing and auxiliary staff are aggrieved by the dearth of facilities and supplies for handwashing and hand-sanitizing.

f. Failure to Implement and Maintain an Injury and Illness Prevention Program

In general, Aurora Santa Rosa suffered from numerous OSHA compliance deficiencies and complaints, resulting from a top-down culture that was generally ad-hoc and reactive as opposed

to vigilant and proactive about health and safety issues.

California Labor Code §§ 6401.7, 6401.8, and 6403.5 require Aurora to have and implement an Injury and Illness Prevention Program ("IIPP") with certain required components and processes. Upon Plaintiff's hiring, the Santa Rosa facility had no IIPP, written or otherwise. During Plaintiff's employment and, upon information and belief, continuing to the present, Aurora did not maintain a written IIPP, did not train all employees about the program, and did not correct unsafe and unhealthy conditions in a timely manner. Upon information and belief, Aurora's HR director from March 2016 to September 2016, Julius Schillinger, began writing an IIPP. However, during Plaintiff's employment, no IIPP was discussed with Plaintiff, the CNO, and she was not aware of any announcements or trainings about the adoption of an IIPP. During Plaintiff's employment period, no IIPP was implemented. Upon information and belief based upon Plaintiff's investigation, Aurora never came into compliance with the IIPP requirements of California law.

VI. Aurora Misrepresented Material Facts in Recruiting Plaintiff, in Violation of Labor Code Section 970

Labor Code § 970 forbids an employer from persuading any person to relocate "from any place outside to any place within the State [. . .] through or by means of knowingly false representations." Aurora misrepresented material terms and conditions of employment to Plaintiff in violation of Section 970 in order to lure her away from a secure CNO position in Virginia. The Company mispresented to Plaintiff the terms and conditions of the position at Aurora with respect to (a) descriptions of her medical and other benefits and (b) failure to disclose to Plaintiff the potential impending sale of the Company at the time that she was to join and misrepresenting the security of the job. The Company lied to Plaintiff outright and by omission. As a result, Plaintiff suffered economic and non-economic damages.

a. Misrepresentation of Plaintiff's Benefits at Aurora

Before Plaintiff was approached by Aurora's recruiter, she had worked for nearly two years as Chief Nursing Officer for the HCA Virginia Health System at Dominion Hospital in Falls Church, VA. In this position, Plaintiff had enjoyed a competitive salary, industry-standard bonus, and high-quality health insurance befitting her management role.

As Plaintiff debated whether to work for Aurora – which would require relocating from Virginia to California and accepting a lower base salary – the comparability of non-salary benefits, and particularly health benefits, was a material and necessary factor in her decision. Before accepting the Aurora position in 2016, Plaintiff emphasized the importance of a strong benefits package to Al Jennings, Human Resources Director for Aurora Santa Rosa at the time. She told him she had high-quality health insurance, describing the health plan coverage, the fact that she paid approximately $150/month in premiums and that her benefits also covered disability. In response, Mr. Jennings assured her that Aurora's standard benefits would be "just as good or better." Relying on his specific representation that the benefits are comparable, Plaintiff accepted the position with Aurora.

After Plaintiff started working in Aurora Santa Rosa, she learned the particulars of

Aurora's standard health benefits. To her surprise, what was available to her from Aurora was markedly inferior to her benefits at HCA. Plaintiff's health insurance plan with Aurora would be drastically worse than her old plan. Contrary to what Mr. Jennings had represented to her, Plaintiff would be expected to pay a much higher premium—over $500 per month—with a higher deductible, higher copay, and less coverage, including no coverage for disability. With full knowledge of Plaintiff's benefits at HCA in Virginia, Mr. Jennings knowingly misrepresented the benefits Aurora would provide in response to Plaintiff's questions about benefits. By the time the Company disclosed the full details of the plan, it was too late because Plaintiff had already relocated and started working at Aurora. Because Aurora's benefits were inferior, Plaintiff declined to enroll and instead relied on COBRA continuation coverage from her former employer.

b. Failure to Disclose Potential Sale of the Company and Misrepresentation about Stability of Company and Job Security

The low quality of her healthcare benefits was not the only shock to Plaintiff in her first days at Aurora. During the recruitment process, Aurora Santa Rosa CEO Kay Seim represented to her that the company was stable, that it was not in trouble of any kind, and that she would have job security. Plaintiff made it clear to Aurora that she was only interested in moving to Santa Rosa if this position would be the last big move in her career. Thus, she was shocked to learn shortly after starting at the hospital that the Company was in the midst of an acquisition and could be sold in a matter of months. As the CNO, Plaintiff became rightfully concerned that her job would be at risk under new management should a new owner wish to "clean house" at the Company's leadership level. While, upon information and belief, potential buyers were near to closing an acquisition deal at the time Plaintiff was considering moving to California, this was never disclosed to her. Plaintiff would not have moved across the country to join a company that was trying to merge or be acquired. The possibility of a change in ownership or restructuring was a material fact that should have been disclosed, given the discussions that Plaintiff had with Seim and Jennings about job security and the fact that she was being recruited for a C-level position.

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On behalf of Plaintiff, we request that the LWDA accept this supplemental PAGA notice and investigate the additional allegations stated herein.

Thank you for your attention to this matter.

Very truly yours,

Xinying Valerian

Enc. Brooke June 19, 2017 Notice to LWDA

Service List:

1. Aurora Behavioral Healthcare – Santa Rosa, LLC, and Signature Healthcare Services, LLC, via certified mail to:
   Derek Sachs
   Lewis Brisbois Bisgaard & Smith LLP
   2020 West El Camino Avenue, Suite 700
   Sacramento, CA 95833

2. Aurora Charter Oak - Los Angeles, LLC, via certified mail to:
   Todd A. Smith
   1161 East Covina Blvd
   Covina, CA 91724

3. Aurora Las Encinas, LLC, via certified mail to:
   Thomas Mahle
   2900 E Del Mar Blvd
   Pasadena, CA 91107

4. Bakersfield Behavioral Healthcare Hospital, LLC, via certified mail to:
   Blair Stam
   2065 Compton Ave
   Corona, CA 92881

5. Aurora - San Diego, LLC, via certified mail to:
   Alain Joe Azcona
   11878 Avenue of Industry
   San Diego, CA 92128

6. Aurora Vista Del Mar, LLC, via certified mail to:
   Jenifer Nyhuis
   801 Seneca St
   Ventura, CA 93001

7. Aurora Behavioral Healthcare-Roseville, LLC, via certified mail to:
   Blair Stam
   2065 Compton Avenue
   Corona, CA 92881

Sanford Heisler Sharp, LLP

Sanford Heisler Sharp, LLP
111 Sutter Street, Suite 975
San Francisco, CA 94104
Telephone: (415) 795-2020
Fax: (415) 495-2021
www.sanfordheisler.com

Kevin Love Hubbard, Associate
(415) 795-2029
khubbard@sanfordheisler.com

New York | Washington D.C. | San Francisco| San Diego | Nashville

June 19, 2017

VIA ONLINE FILING
Labor and Workforce Development Agency

Re: Labor Code Private Attorney General Act of 2004 – Notice on behalf of Teresa Brooke

Dear Labor and Workforce Development Agency:

This letter provides notice on behalf of Teresa Brooke ("Plaintiff"), a former employee of Aurora Behavioral Healthcare – Santa Rosa, LLC, a subsidiary of Signature Healthcare Services, LLC ("Aurora" or "the Company"), pursuant to the California Private Attorneys General Act of 2004, the Labor Code §2699.3. We request that the LWDA investigate violations of the Labor Code, including without limitation, Cal. Lab. Code section 1102.5(a)-(d), Cal. Lab. Code section 6310 and 6311, at Aurora. Aurora has also violated Cal. Lab. Code section 1198.5 by failing to produce Plaintiff's personnel file. We also request that the LWDA provide notice to Plaintiff through the undersigned legal counsel if it chooses not to investigate the allegations.

Aurora Behavioral Healthcare – Santa Rosa is one of a series of psychiatric hospitals owned by Signature Healthcare Services, a Michigan-based Limited Liability Company. Plaintiff worked for Aurora as a Chief Nursing Officer in Santa Rosa, California from May 2016 to November 2016, when she was terminated for complaining about and refusing to participate in company practices violating the California Code of Regulations ("CCR"), the California Occupational Safety and Health Act, and the California Health & Safety Code.

Aurora Maintains Nurse-to-Patient Staffing Ratios that Violate the California Code of Regulations and Create a Dangerous Environment for Hospital Staff and Patients

Title 22, Division 5, section 70217(a)(13) of the California Code of Regulations, implementing California Health & Safety Code section 1276.4 provides:

> (13) The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes of psychiatric units only, "licensed nurses" also includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed nurses on the unit.

Throughout Plaintiff's employment at the Company, Aurora failed to meet these minimum requirements and failed to make necessary staffing adjustments after Plaintiff repeatedly expressed concern regarding the facility's noncompliance. When she started work at Aurora, Plaintiff observed that only one or two licensed nurses were assigned to cover more than 19 patients. 22 CCR § 70217(a)(13) requires that psychiatric units maintain a nurse-to-patient ratio of 1:6 or fewer at all times. Aurora's nurse-to-patient ratio was more than 1:19 or worse at the start of Plaintiff's employment. This ratio fell even lower on nights and weekends, or when nurses called in sick.

Plaintiff immediately notified Aurora's leadership of the Company's violation of the regulation and began lobbying to improve its staffing ratios and other regulatory shortfalls. Then-CEO Kay Seim acknowledged the problem and supported Plaintiff's efforts. She allowed Plaintiff to hire travel nurses on a contractual basis to boost staff numbers temporarily. CEO Seim also granted Plaintiff latitude to limit patient admissions to a number the facility's staff was permitted to supervise under Title 22. Moreover, CEO Seim was supportive of Plaintiff's request that Aurora consider raising nurses' wages, which were significantly below the market rate, resulting in a high rate of attrition of hospital staff and an inability to meet staffing ratio requirements.

However, Plaintiff met significant resistance from the Company's management, including Aurora's then-Chief Financial Officer, Susan Rose, and Signature Healthcare Services Vice President of Clinical Operations, Michael Sherbun. CFO Rose and VP Sherbun, along with the Company's corporate leadership, ignored Plaintiff's requests to ensure compliance with California Health and Safety Code and accompanying regulations, and continued to insist that the facility increase patient admissions and lower staffing costs. The Company's leadership disregarded Plaintiff's complaints and emails and dodged her requests to meet in person to discuss the need for additional staff. Moreover, they pressed to open an additional unit at the Company's Santa Rosa facility, despite their awareness of these glaring staff deficiencies.

Due to this resistance from the Company's management, Plaintiff was unable to hire more permanent staff or cap patient admissions. The hospital remained noncompliant with the staffing ratios required by law. Conditions for patients and staff deteriorated. Throughout the summer and early fall of 2016, the facility's insufficient and illegal staffing exhausted Aurora's nurses, many of whom were forced to work 16-hour shifts and miss meal periods to make up for personnel shortages. This resulted in regular injuries to staff. Losing nurses to injuries and medical leave only exacerbated staffing deficiencies. Additionally, understaffing during this period led to a series of injuries and violent incidents among patients, who were chronically under-supervised. The situation went from merely noncompliant to dangerous.

Plaintiff continued to complain to the Company's leadership. She discussed the understaffing problem on a weekly basis with CEO Seim in one-on-one meetings and regularly expressed concern to all C-level directors at routine "flash meetings." Following patient and staff incidents throughout the fall, Plaintiff met with the Company's HR to reiterate her complaints. In one instance, after another nurse sent an email to management expressing concern about staffing shortages, Plaintiff broached the issue with CFO Rose, who suggested that nurse should be fired for complaining. Throughout October 2016, Plaintiff attempted to meet in person with VP

Sherbun to discuss a solution, but he avoided her. All the while, the Company's leadership continued to press for the opening of a new unit.

Aurora Retaliated Against Plaintiff for Complaining of the Company's Noncompliance to Company Management and to the California Department of Public Health, In Violation of Cal. Lab. Code Section 1102.5 (a-d), and Cal. Lab. Code section 6310 and 6311.

On October 27, 2016, the Company abruptly fired CEO Seim. Upon information and belief, her termination was a result of her efforts to support Plaintiff's efforts to blow the whistle on the Company's illegal practices, bring the Company into compliance, and resist the opening of an additional hospital unit that would only exacerbate the problem.

After it fired CEO Seim, the Company selected Susan Rose as the new CEO. Ms. Rose had staunchly resisted Plaintiff's and CEO Seim's efforts to hire more staff and had aggressively pushed to open the additional unit. In her first days as Aurora's CEO, Ms. Rose immediately reversed Plaintiff's efforts, several months in the making, to mitigate the staffing shortages. Ms. Rose suspended the use of travel nurses and divested Plaintiff of the authority to overrule the Administrator-On-Call on patient admission decisions. Seizing that authority for herself, Ms. Rose pushed to maximize the number of patients admitted, even though she knew this would exacerbate the facility's noncompliance and risk further injuries to the patients and staff.

Plaintiff had lost her only ally at the Company, and was unable to stand by as the Company continued its unlawful operations. To ensure that the Company ceased its illegal practices and improve the unsafe working conditions at Aurora, Plaintiff filed a complaint with the California Department of Public Health ("CDPH") at the end of October 2016. In her CDPH complaint, Plaintiff detailed Aurora's staffing deficiencies, unsafe working conditions, and endemic noncompliance with California law.

On November 17, 2016, the CDPH's Licensing & Certification Program made an unannounced visit to Aurora to investigate Plaintiff's claims. CDPH substantiated and validated Ms. Brooke's complaint and instructed Aurora to close one of its four operational units.

In retaliation against Plaintiff's whistleblower complaint to the CDPH, Aurora terminated her employment on November 25, 2016, one week after the surprise CDPH visit.

Aurora's explanation for terminating Plaintiff was plainly pretextual. The Company wrote on Plaintiff's notice of termination that her "performance did not meet expectations." This is simply not true. Plaintiff was a high performing employee who, in her only performance evaluation, received a glowing review before her engagement in protected activities. Ms. Brooke was not terminated for performance issues. Rather, the Company targeted her for termination upon learning of her CDPH complaint, one that was meant to bring the facility into compliance with state statutes and regulations, protect patients, and ensure safe working conditions for staff at Aurora.

Aurora Failed To Produce Plaintiff's Personnel File

Plaintiff's counsel has requested that the Company produce Plaintiff's personnel file on several occasions but has received no response from the Company. In a letter addressed to Ms. Rose and received via Federal Express on May 3, 2017, Plaintiff's counsel requested that the Company produce her personnel file. The Company has neither responded nor complied with the request. Plaintiff's counsel had previously sent the same letter to the Agents for Service of Process for both Aurora Behavioral Healthcare – Santa Rosa and Signature Healthcare Services, LLC (received via Federal Express on April 25, 2017 and April 27, 2017, respectively). To date, neither entity has produced Plaintiff's personnel file.

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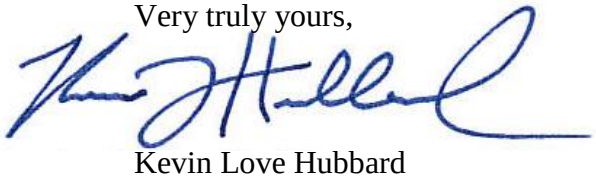
The Private Attorney General Act (Labor Code section 2698 et seq.) entitles an employee to recover civil penalties for violations of the Labor Code on behalf of herself and others. An employer that violates section 1102.5 is liable for $10,000 in civil penalties. An employer that violates section 6310 and 6311 is liable for $100 for each aggrieved employee per pay period for the initial violation and $200 for each aggrieved employee per pay period for each subsequent violation. Finally, an employer that violates section 1198.5 is liable for a penalty of $750. Plaintiff therefore makes this complaint on behalf of herself.

On behalf of our client, we request that the LWDA investigate the alleged violations, or provide timely notice to the undersigned if it chooses not to investigate the allegations.

Thank you for your attention to this matter.

Very truly yours,

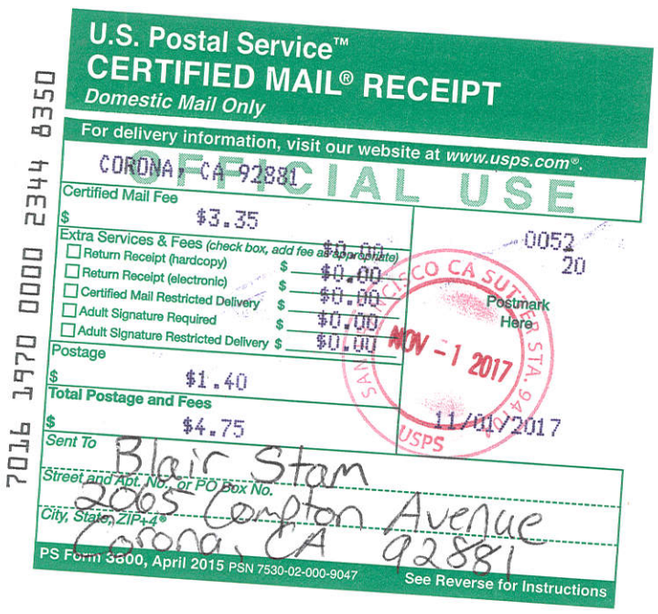


Kevin Love Hubbard

CC: Aurora Behavioral Healthcare – Santa Rosa, LLC and Signature Healthcare Services, LLC, c/o Blair Stam, via certified mail.

Signature Healthcare Services, LLC, c/o Laura Sanders, via certified mail.

Aurora Behavioral Healthcare – Santa Rosa, LLC, c/o Susan Rose, via certified mail.



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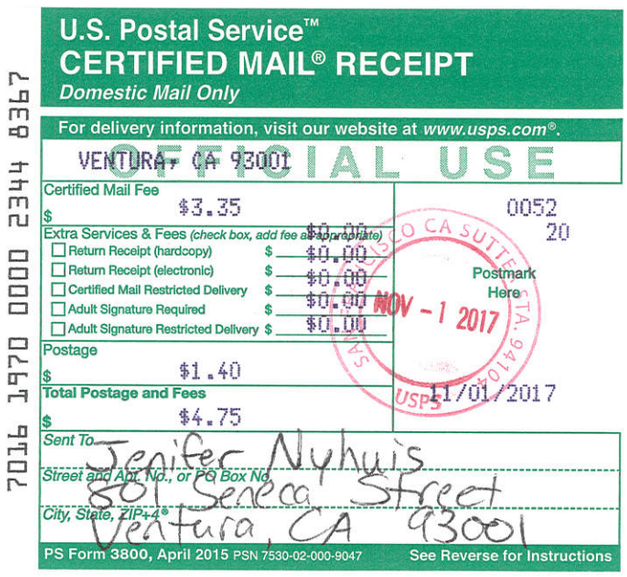

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